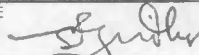



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01 28214

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE M. NAGLE | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 18 '81 | | 2b. HOUR 6:00A |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 24, 1943 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH LA. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | 12b. KIND OF BUSINESS OR INDUSTRY HIGH'S STORE | |
| 13a. STATE MD. | | | 13b. COUNTY BALTO. | 13c. CITY OR TOWN LOCKEYSVILLE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT L. MURDOCK | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE GRAY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 240 01301A | | |
| 17. INFORMANT FAMILY RECORDS | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 METASTATIC CARCINOMA OF BREAST IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-13 , 19 81 , to 11-18 , 19 81 , that (I) (we) lost saw the deceased alive on 11-18 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE  | | DEGREE MD | | 22c. DATE SIGNED 11-18-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. GIRDHAR, M.D. | | 22e. ADDRESS GBMC-6701 N. CHARLES ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 11-21-1981 | 23c. NAME OF CEMETERY OR CREMATORY DUBLANEY VALLEY | | 23d. LOCATION CITY OR TOWN COUNTY STATE TIMONIUM BALTO. MD. | |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES 2325 YORK RD. | | ADDRESS 2325 YORK RD. | | 25a. DATE REC'D. BY REGISTRAR NOV 27 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11 18 181 6:00

WAGLE

M.

WELLIE

88

WHITE

FEMALE

BALTIMORE COUNTY

68MC-6701 N. CHARLES ST.

TOWSON

METASTATIC CARCINOMA OF BREAST

13

11-18

81

11-18

11-18

18-81-11

X

68MC-6701 N. CHARLES ST.

S. GIBSON, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 1 5

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Helen Naylor | | | 2a. DATE OF DEATH MONTH DAY YEAR November 6, 1981 | | 2b. HOUR 7:15 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 5, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS. MONTHS DAYS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | |
| 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | 13a. STREET ADDRESS 111 West Road | | | | |
| 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown Naylor | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-54-0827 | | 17. INFORMANT ADDRESS Henry L. Rocklin, Jr. Fayette & Calvert St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c) 10 years | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 2, 1977 to November 6, 1981 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on November 4, 1981 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Donald O. Wood, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald O. Wood, M.D. | | | | 22e. ADDRESS 2 Greenwood Drive Timonium, Md. 21093 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-9-81 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto., Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 9 1981 | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 1 6

| | | | |
|--|---|---|---|
| FOR 1- STATE REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) JIMMY B. NEAL | | 2a DATE OF DEATH MONTH DAY YEAR November 29, 1981 2b HOUR 3:30P ^M | |
| 3 SEX Male | 4 RACE Caucasian | 5 DATE OF BIRTH 7-16-1928 YEAR | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 53 yrs. | 7a BIRTHPLACE (STATE OR FOREIGN) North Carolina | | 7b CITIZEN OF WHAT COUNTRY? USA |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10 CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector |
| 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | 13a STREET ADDRESS 21236 9511 Perry Hall Blvd. | |
| 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 14 FATHER'S NAME FIRST MIDDLE LAST Raleigh Neal | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Massey | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | |
| 16b SOCIAL SECURITY NO. WWII 215-24-1764 | | 17 INFORMANT ADDRESS 21236 Jane P. Neal 9511 Perry Hall Blvd. | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Rectum DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) _____ | | | |
| MEDICAL CERTIFICATION | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that XX (this hospital) attended the deceased from November 27 , 19 81 , to November 29 , 19 81 , that X (we) lost saw the deceased alive on November 29 , 19 81 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | 22c. DATE SIGNED 11/29/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin Keating M.D. | | 22e. ADDRESS 9000 Franklin Square Drive, 21237 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-2-81 | |
| 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | |
| 24. FUNERAL HOME NAME Schimunek Funeral Home, Inc. 9705 Belair Road 21236 | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|--|--|
| #1. Film 0562 12/11/81 kam | | STATE OF MARYLAND | | 8 1 2 8 2 1 7 | |
| 1 - STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | CERTIFICATE OF DEATH | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a DATE OF DEATH MONTH DAY YEAR | |
| Frederick James Neiser | | Neiser | | Nov. 16 1981 12:00 P.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | |
| Male | | White | | 02 21 1894 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Pennsylvania | | USA | | 87 YRS | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Rossville | | Franklin Square Hospital | | Baltimore, County MD. | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | 13a STREET ADDRESS | |
| Signal Depot | | U.S. Government | | 9719 Philadelphia Road 21237 | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | |
| Maryland | | Baltimore | | Nottingham | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| George Henry Neiser | | Anna Messenger | | No | |
| 16b SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | |
| 216-10-8094 | | Bertha Schroeder 9719 Philadelphia Rd | | Myocardial Insufficiency | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | Patient | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | Scen 2 + L.R. | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | From H. in Sq. Hwy. | |
| 22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Nov. 12 1981, and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | |
| William A. Tyson | | MD. | | 11-16-81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | |
| William A. Tyson | | Box 158 Kingsville Md. 21087 | | NOV 23 1981 | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 11/19/81 | | Gardens of Faith | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Overlea Baltimore Md. | | NOV 23 1981 | | Frances Jean Nathan | |
| 24 FUNERAL DIRECTOR NAME | | ADDRESS | | 25a DATE REC'D. BY REGISTRAR | |
| Lacash Funeral Home | | 7901 Bala Rd | | NOV 23 1981 | |

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 2 8 2 1 8 | |
|--|--|--|--|--|--|---|--|--|----------------------|--|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth Neueder | | | | | | 2a. DATE OF DEATH November 29, 1981 | | | 2b. HOUR M | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH Aug. 4, 1896 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 | | 7a. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7b. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | | MD. | | |
| 10 CITY OR TOWN OF DEATH Ruxton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Parkville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Balt., Md. 21234 2221 Wilker Avenue | | | |
| 14 FATHER'S NAME FIRST Joseph MIDDLE LAST Hacklinger | | | | 15 MOTHER'S MAIDEN NAME FIRST Magdalena MIDDLE LAST Leipfinger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-54-8414 | | 17 INFORMANT Daughter: Elfriede Morgan | | ADDRESS Balt., Md. 21234 2221 Wilker Avenue | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) Arteriosclerotic Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Vascular Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 2 mo. Year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (D) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from Aug 23 Nov 81 to 29 Nov 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (I/did) (I/did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Marc Leavey, M.D. | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 30 Nov 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marc Leavey, M.D. | | | | | | 22e. ADDRESS 7600 Osler Drive Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 2 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 30 1981 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

BP

November 23, 1951

Director

Washington

Re: [illegible]

WFO

WFO

WFO

Washington, D.C.

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO

WFO



WFO

WFO

Items #10a-22a Film G564 2/8/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28219

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---------------------------------|--|------------------------|--|--------------|--|---------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ROBIN | | MIDDLE LYNN | | LAST NORRIS | | 2b. DATE KNOWN OF DEATH ESTIMATED | | MONTH 11 | | DAY 29 | | YEAR 1981 | | 2b. HOUR M | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR APR. 2, 1956 | | 6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | MONTH 11 | | DAY 29 | | YEAR 1981 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7507 Labyrinth Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | | | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 739 HOWARD RD. | | 13f. CITY OR TOWN BALTO., MD | | 13g. ZIP CODE 21208 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DONALD H. CAPLAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOAN E. KRAMER | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-76-1030 | | 17. INFORMANT PAUL NORRIS | | ADDRESS 739 HOWARD RD. BALTO., MD | | 21208 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Codeine intoxication</u> 3040 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) Assistant | | MEDICAL EXAMINER | | DATE SIGNED 11-29-81 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE NOV. 30, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH | | 23d. LOCATION CITY OR TOWN BALTIMORE | | COUNTY MARYLAND | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80



100% COTTON FIBER

100% COTTON FIBER



Handwritten signature or mark.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

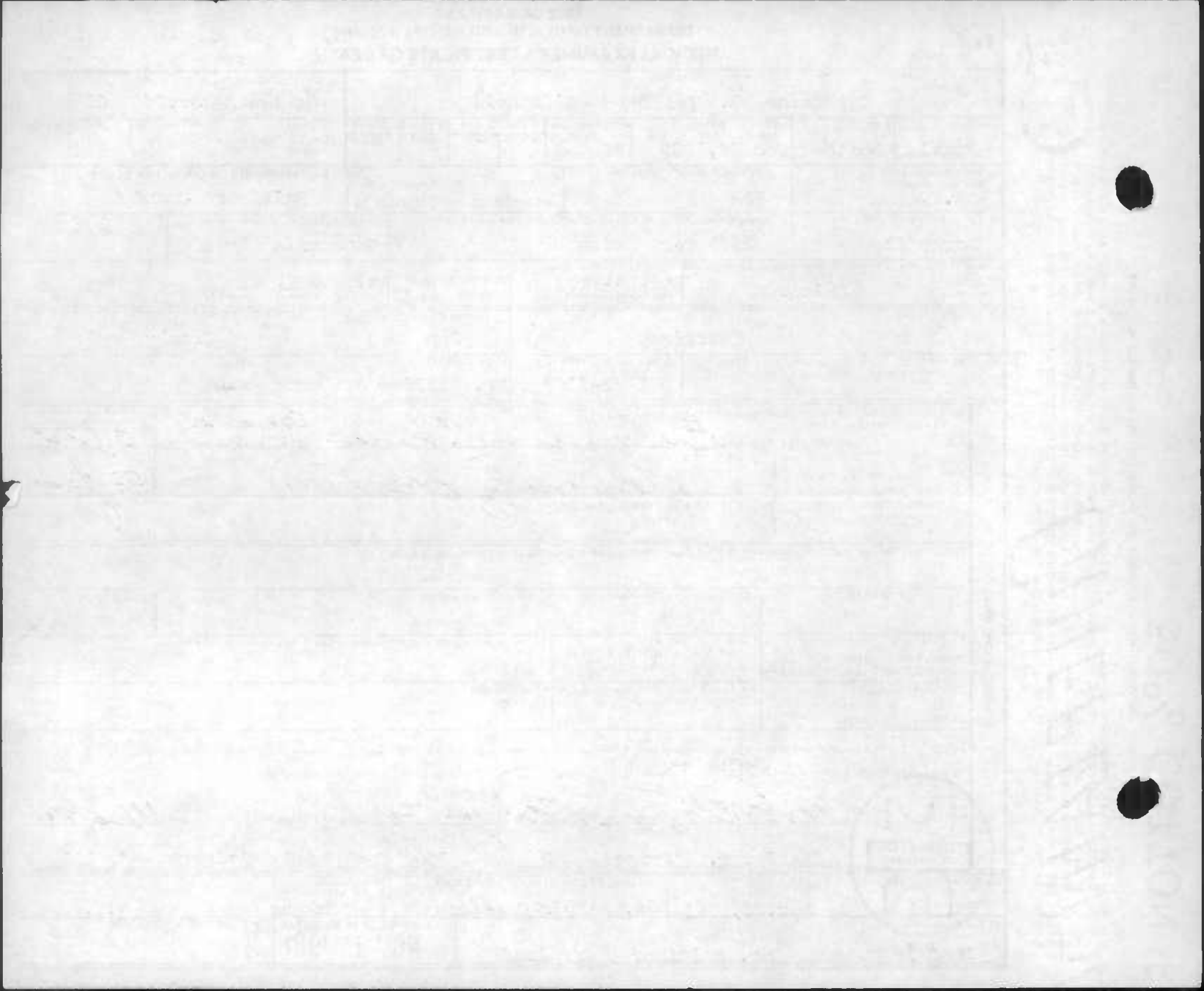
REG. NO.

28220

1- FOR
STATE
REGISTRAR

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Catherine C. (Kitty) O'Connell | | 2a. DATE KNOWN OF DEATH ESTIMATED Nov. 24 1981 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1889 | 6. AGE (IN YEARS) LAST BIRTHDAY 91 YRS. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Parkville | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7309 Park Drive | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE Md. | 13b. COUNTY Balto. | 13c. CITY OR TOWN Parkville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 7309 Park Drive |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Morrisey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Crosby | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 062-42-2189 | | 17. INFORMANT ADDRESS Mr. William J. Horne same |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema & Bronchitis 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Generalized ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days 5 1/2 yrs. | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | TITLE (SPECIFY) Deputy | | DATE SIGNED 11/25/84 |
| EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell MD | | ADDRESS 7501 York Road Baltimore, Md. 212 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Nov. 28, 1981 | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Yonkers N.Y. | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR NOV 27 1981 | | 25b. REGISTRAR'S SIGNATURE Thomas J. Carthagen |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 2 1

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|---|---|--------------------------|-----------------------------------|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a DATE OF DEATH | | | 2b HOUR | | |
| EDITH F. OGLE | | | 11 18 81 | | | 6:05 AM | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7 IF UNDER 1 YEAR | | |
| FEMALE | WHITE | 11 13 1886 | 95 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | BALTIMORE COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| CATONSVILLE | SUMMIT NURSING HOME | HAIRDRESSER | SELF-EMPLOYED | | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b STATE | 13c COUNTY | 13d CITY OR TOWN | 13e INSIDE CITY LIMITS? | 13f STREET ADDRESS | | | |
| MARYLAND | BALTIMORE | ARBUTUS | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1002 LEEDS AVENUE, 21229 | | | | |
| 14 FATHER'S NAME | 15 MOTHER'S MAIDEN NAME | 16 ADDRESS | | | | | | |
| PATRICK | FLANNERY | SARAH GLENNON | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b SOCIAL SECURITY NO. | 17. INFORMANT | | | | | | |
| NO | 212-24-9965 | MARGARET DEEMS 1002 LEEDS AVENUE, 21229 | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardio-Renal failure</u> | | | | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) <u>A.S. Cardiovascular disease</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) <u>Advanced senility</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: b | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| | | | P.M. 19 | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION (CITY OR TOWN, COUNTY, STATE) | | |
| | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Sept 1981</u> to <u>Nov 18, 81</u> , 19 <u>81</u> that (I) (we) last saw the deceased alive on <u>Nov 6, 1981</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b SIGNATURE <u>Stanley Ankudas</u> | | | DEGREE <u>M.D.</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <u>11.18.81</u> |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e ADDRESS | | | | | |
| STANLEY ANKUDAS, M.D. | | | 1101 MAIDEN CHOICE LANE | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (CITY OR TOWN, COUNTY, STATE) | |
| BURIAL | | | 11-20-81 | | NEW CATHEDRAL | | BALTIMORE CITY MARYLAND | |
| 24 FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE |
| HUBBARD FUNERAL HOME, INC. | | | 4107 WILKENS AVE. | | | NOV 20 1981 | | <u>Francis J. Nathan</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 2 8 2 2 2 | |
|--|--|---|--|---|---|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT G O'MALLEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 19 81 | | | b. HOUR 6 12 AM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 07 01 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY INSURANCE | | | |
| 13a. STATE Md | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BAL. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6030 QUEENS FERRY Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD J. O'MALLEY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE KNOX | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) ? | | 17. INFORMANT Mrs. EVELYN G. O'MALLEY | | ADDRESS SAME | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1 Hr.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old myocardial infarction</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE OR CONDITION GIVEN IN PART 1: <u>Old myocardial infarction</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> 19 <u>75</u> , to <u>11-19</u> 19 <u>81</u> that (I) (we) lost saw the deceased alive on <u>11-19</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not, view the body after death, 81 | | | | | | | | | | | |
| 22b. SIGNATURE <u>A.M. Ghiladi M.D.</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-19-81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.M. GHILADI M.D. | | 22e. ADDRESS 7600 OSLER Dr. TOWSON 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 11-21-1981 | | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR J. Walter Conklin | | 24a. ADDRESS 3444 BELAIR RD. | | 24b. DATE REC'D. BY REGISTRAR NOV 23 1981 | | 24c. REGISTRAR'S SIGNATURE Anne J. [Signature] | | | | | |



10 21 21

AMERICAN COUNTY

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

10 21 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 2 8 2 2 3 | |
|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Chester Bernard OTTINGER, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR November 9, 1981 | | 2b. HOUR 5:48 P.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 17, 1912 | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Rossville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Shipyard |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN 21162 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Ottinger | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Blanche Travis | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1927-29 | 17. INFORMANT ADDRESS J. Velma Ottinger White Marsh, MD 21162 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>4275</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>6/16</u> , 19 <u>80</u> , to <u>7/29</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>7/29</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body death. | | | | | |
| 22b. SIGNATURE <u>Larry Wilson MD</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>11/10/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Larry Wilson | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 13, '81 | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gar. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., MD |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | ADDRESS 8521 Loch Raven Blvd. | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1981 | |

NOTION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 28 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH: 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 28224 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Blair Owens | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 13 19 81 | |
| 2b. HOUR M | | | | | | | | | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 3. SEX male | | | | | | | | | | 2d. HOUR 2:56 | |
| 4. RACE white | | | | | | | | | | 2e. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 5. DATE OF BIRTH MONTH DAY YEAR July 17, 1930 | | | | | | | | | | 2f. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS. | | | | | | | | | | 2g. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | | | | | | | 2h. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 2i. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 2j. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | | | | | | | | | 2k. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 10. CITY OR TOWN OF DEATH Woodlawn | | | | | | | | | | 2l. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2027 Gwynn Oak Avenue | | | | | | | | | | 2m. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab Driver | | | | | | | | | | 2n. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 12b. KIND OF BUSINESS OR INDUSTRY Diamond Cab | | | | | | | | | | 2o. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 13a. STATE Maryland | | | | | | | | | | 2p. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 13b. COUNTY Baltimore | | | | | | | | | | 2q. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 13c. CITY OR TOWN Woodlawn | | | | | | | | | | 2r. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 2s. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 13e. STREET ADDRESS 2027 Gwynn Oak Ave. | | | | | | | | | | 2t. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 13f. ZIP CODE 21207 | | | | | | | | | | 2u. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Burks Owens | | | | | | | | | | 2v. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel May Rorrer | | | | | | | | | | 2w. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | | | 2x. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 16b. SOCIAL SECURITY NO. 223-36-7946 | | | | | | | | | | 2y. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 17. INFORMANT Baltimore, Md | | | | | | | | | | 2z. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 81 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 429.2 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 19c. AUTOPSY? | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | 20d. LOCATION CITY OR TOWN COUNTY STATE | |
| 20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 20f. LOCATION CITY OR TOWN COUNTY STATE | |
| 20g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 20h. LOCATION CITY OR TOWN COUNTY STATE | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | |
| 23. ACTUAL SIGNATURE Hormez R. Guard, M.D. | | | | | | | | | | 23. TITLE (SPECIFY) Assistant | |
| 24. EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | | | | | | | 24. DATE MEDICAL EXAMINER SIGNED 11/14/81 | |
| 25. ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | 25. DATE MEDICAL EXAMINER SIGNED 11/14/81 | |
| 26a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | | | | | | | 26b. DATE 11/16/81 | |
| 26c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | | | | | | | | | 26d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md. | |
| 26e. NAME 8728 Liberty Rd. Randallstown, Md | | | | | | | | | | 26f. DATE REC'D. BY REGISTRAR NOV 17 1981 | |
| 26g. NAME Loring Byers Funeral Directors, Inc. 21133 | | | | | | | | | | 26h. REGISTRAR'S SIGNATURE James J. [Signature] | |

MEDICAL CERTIFICATION



THE WATSON
POWELL
CO. LONDON, ENGLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 2 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) John Melvin Parks Sr | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-4-81 | | 2b. HOUR 5:20AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09-20-20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Randallstown, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN INSURE HEALTH PLAN, GIVE STREET ADDRESS) Baltimore County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY Electrical | | |
| 13a. STATE Maryland | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Reisterstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Parks | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Allen | | 13e. STREET ADDRESS 220 Cockeys Mill Rd. #21136 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT John M. Parks, Jr, Reisterstown Md. Rd | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency (Clinical)</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA cannot be R/O partial Autops 7 only</u> <u>Diffuse Pulmonary Edema & Congestion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible CVA cannot be R/O, Partial Autops 7</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HRS</u> <u>HRS</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>OLD Myocardial Infarct of L.V. of Heart</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? <u>NO</u> LIMITED <u>NO</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Bridget C. Kahntroff, M.D.</u> | | DEGREE ASSISTANT PATHOLOGIST ATTENDING <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>11-4-81</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BRIDGET C. KAHNTROFF, M.D.</u> | | 22e. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE IF) Burial | | 23b. DATE 11/7/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME Lemmon-Mitchell - Wiedefeld | | | | 25a. DATE REC'D. BY REGISTRAR NOV 6 1981 | | 25b. REGISTRAR'S SIGNATURE <u>James Jean Nathan</u> | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 2 6

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Grace Parr | | | 2a. DATE OF DEATH MONTH 11 DAY 16 YEAR 81 | | | 2b. HOUR 11:17A_M | | | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH Oct. DAY 15 YEAR 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. Charles St. 21204 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Lutherville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 604 Goucher Avenue | | |
| 14. FATHER'S NAME FIRST William MIDDLE Ridgley LAST Sedicum | | | | 15. MOTHER'S MAIDEN NAME FIRST Pricilla MIDDLE Morgan LAST | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. 215-09-0396B | | | | 17. INFORMANT Mrs. Ruth Berwanger | | | | ADDRESS 604 Goucher Avenue | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASCVD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Min. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/15 19 81 to 11/16 19 81 , that (I) (we) lost saw the deceased alive on 11/16 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Leo Cherrick | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/16/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leo Cherrick, M.D. | | | | | | 22e. ADDRESS 6701 N. Charles St. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 11/19/81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY its Maryland STATE | | | | |
| 24. FUNERAL DIRECTOR NAME Ambrose Funeral Home ADDRESS 1328 Sulphur Spring Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 17 1981 | | | | | |

MEDICAL CERTIFICATION

FORM 100-10

RECEIVED

RECEIVED
FEB 11 1961
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.



11 11 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of interment with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 2 8 2 2 1 | |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) ATHOL Vivian PECK | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 17 81 | | 2b. HOUR 8 A. M. |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR July 30, 1895 | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Sudbrook Park | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leidy Meadows | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown Tyson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 193-18-1479 | | 17. INFORMANT ADDRESS Mr. Karl C. Peck Baltimore, Maryland 21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5789 Complete Heart Block | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30' |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction | | | | | 24 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) Upper GI Bleed | | | | | 3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-12 , 19 81 , to 11-17 , 19 81 , that (I) (we) last saw the deceased alive on 11-17 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Richard E. Turnbull | | | | 22c. DATE SIGNED 11/17/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Turnbull | | | | 22e. ADDRESS Balt County Genl Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE November 19, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial | |
| 24. FUNERAL DIRECTOR NAME Lorina Buers Funeral Directors | | 25a. DATE RECD. BY REGISTRAR NOV 17 1981 | | 25b. REGISTRAR James S. [Signature] | |
| 26. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133 | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, but may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Alice M. Pedersen | | | 2a. DATE OF DEATH MONTH DAY YEAR November 22, 1981 | | 2b. HOUR 2:25 A.M. |
| 3 SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | IF UNDER 1 YEAR MONTH DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD | | |
| 10. CITY OR TOWN OF DEATH Towson | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | 12b. KIND OF BUSINESS OR INDUSTRY Education | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Towson | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 960 Beaverbank Circle |
| 14. FATHER'S NAME FIRST MIDDLE LAST James P. Peterson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Sund | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 413-56-9139 A | | 17. INFORMANT ADDRESS Rev. Dr. David B. Pedersen Same as #13. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Vascular Accident - 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Diabetes Mellitus. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1981 to Nov 22, 1981 that (I) (we) last saw the deceased alive on Oct 19, 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE M.D. | | 22c. DATE SIGNED 11-23-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Venable, M.D. | | 22e. ADDRESS 7215 York Road Baltimore, Maryland 21212 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE Nov. 23, 1981 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | ADDRESS 1050 York Road Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR NOV 24 1981 | 25b. REGISTRAR'S SIGNATURE [Signature] |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #6 per phone call / Fun. Home
FOR 11/25/81 rc
1. STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) NICHOLAS GRIFFITH PENNIMAN, III | | | 2a DATE OF DEATH MONTH DAY YEAR November 17, 1981 | | | 2b HOUR / 10 M | | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR April 4, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 73 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | |
| 10 CITY OR TOWN OF DEATH Towson | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney | | 12b KIND OF BUSINESS OR INDUSTRY Law | | |
| 13a STATE Maryland | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Owings Mills | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 12427 Park Heights Avenue | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George Dobbin Penniman | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet W. Duschane | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 09 0454 | | 17 INFORMANT ADDRESS T. Courtney Jenkins, Balto., Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 } DUE TO, OR AS A CONSEQUENCE OF Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 years</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> 19 <u>74</u> to <u>Nov 17</u> 19 <u>81</u> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>11/17</u> 19 <u>81</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> did not view the body after death. | | | | | | | | | | |
| 22b SIGNATURE <u>William F. Fritz</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 11/17/81 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William F. Fritz, M.D. | | | 22e ADDRESS 2 W. University Parkway, Balto., Md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 11/21/81 | | 23c NAME OF CEMETERY OR CREMATORY St. Thomas | | 23d LOCATION CITY OR TOWN COUNTY STATE Garrison Forest, Md. | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | | 25a DATE REC'D. BY REGISTRAR NOV 19 1981 | | 25b REGISTRAR'S SIGNATURE <u>Francis J. Nathan</u> | | |

NICHOLSON, 21 FIFTH PENNS. W. III, November 12, 1931

April 1, 1932

Baltimore Group

Wife

USA

Law

Greater Baltimore Medical Center

Town

12427 Park Heights Avenue

Baltimore Owings Mills

Maryland

Eusebio

W.

Harris

Penniman

Dobbin

George

215 08 084 T. Courtney Jenkins, Balto., Md.

No

WILLIAM F. FRITZ, M.D., 112 W. University Parkway, Balto., Md.

Dr. William F. Fritz, M.D., 112 W. University Parkway, Balto., Md.

St. Thomas

11/21/31

Burial

Henry W. Jenkins & Sons Co.

4505 York Road Balto., Md. 21212

Garrison Forest, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Grace Virginia Pennington</u> | | | | 2a. DATE OF DEATH MONTH <u>November</u> DAY <u>30</u> YEAR <u>1981</u> | | | | 2b. HOUR <u>7:20 a.m.</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>08</u> DAY <u>17</u> YEAR <u>1926</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>55</u> YRS. | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>Middle River</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>1502 Dornton Avenue 21220</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u> | |
| 13a. STATE <u>Maryland</u> | | | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Middle River</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>Howard</u> LAST <u>Ritter</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Jessie</u> MIDDLE <u></u> LAST <u>McCallister</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | | 16b. SOCIAL SECURITY NO. <u>217-22-2102</u> | | 17. INFORMANT ADDRESS <u>Charles H. Pennington 1502 Dornton Ave</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>10 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1) Abdominal aortic aneurysm 2) Collagen Vascular Disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u> | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>October</u> 19 <u>71</u> , to <u>November 30</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>November 13</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Henry I. Babitt, M.D.</u> | | | | DEGREE <u>M.D.</u> | | | | 22c. DATE SIGNED <u>November 30, 1981</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Henry I. Babitt, M.D.</u> | | | | 22e. ADDRESS <u>2724 North Charles St., Balto</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>12/3/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | | 23d. LOCATION CITY OR TOWN <u>Parkville</u> COUNTY <u>Baltimore</u> STATE <u>Md.</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Lassahn Funeral Home</u> | | | | ADDRESS <u>7401 Belair Road</u> | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 3 1981</u> | | 25b. REGISTRAR'S SIGNATURE <u>Thane J. [Signature]</u> | |



1891 6330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 1 2 8 2 3 1 | |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Edwin Emmart Pierpont</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 1, 1981</i> | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 24, 1906</i> | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> | |
| 10. CITY OR TOWN OF DEATH <i>Pikesville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Milford Manor Nursing Home</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>unemployed</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>MD</i> | | | | 13b. COUNTY <i>Balto.</i> | |
| 13c. CITY OR TOWN <i>Rockdale</i> | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter J. Pierpont</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elva O. Emmart</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-60-4927</i> | | 17. INFORMANT ADDRESS <i>719 Hillcrest Dr. Mr. Robert Pierpont Bradenton, Fla. 33529</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C.V.A.</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Myocardial Infarction</i> (c) <i>Arteriosclerosis</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>10 years</i> <i>8 years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 10, 1950</i> to <i>Nov 1, 1981</i> , that (I) (we) last saw the deceased alive on <i>Oct 30, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Edwin C. Pierpont, MD</i> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EDWIN C. PIERPONT, MD</i> | | | | 22e. ADDRESS <i>8204 LIBERTY RD. BALTO, 21207 MD</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>11/3/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive Cemetery</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Randallstown Balto. MD</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Loring Byers Fuernal Directors</i> ADDRESS <i>8728 Liberty Rd. Randallstown, Md. 21133</i> | | | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <i>James J. Smith</i> | |

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 3 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard Taft Pitts | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 29, '81 | | 2b. HOUR 10:55 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 02 12 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Williamstown, W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Motor Freight Express | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Randallstown | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 9124 Liberty Road, 21133 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lewis Pitts | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Carter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 218-03-9325 | | 17. INFORMANT ADDRESS Mrs. Viola Pitts, Randallstown, Maryland 9124 Liberty Road, 21133 | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Respiratory arrest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 min 10 yrs |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1980 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 19 Nov 29 19 81 , that (I) (we) lost saw the deceased alive on Nov 29, 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Daniel Bakal | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-29-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Bakal | | M.D. | | 22e. ADDRESS Reisterstown Rd., & Slade Ave., Pikesville, Md. | | | |

| | | | | | | | |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/02/81 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Holbrook, Baltimore Co., Md. 21133 | |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors Inc. 8728 Liberty Road, Randallstown, Md. 21133 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Rose J. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 3 3

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
Anna Loretta Plough2a. DATE OF DEATH MONTH DAY YEAR
Nov. 25, 19812b. HOUR A.
6:30 M.

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
Jan. 7, 1905

6. AGE (IN YEARS LAST BIRTHDAY)

76 YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Baltimore, Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County, MD.

10. CITY OR TOWN OF DEATH

Catonsville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
37 Briarwood Road

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Catonsville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

37 Briarwood Road

14. FATHER'S NAME

FIRST MIDDLE LAST
William J. Kroeger

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Emma S. Welch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)
216-24-2123

17. INFORMANT

ADDRESS
Mrs. Regina Singleton-202 Rolling-

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1509
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Field Rd.-Catonsville
CARCINOMA OF ESOPHAGUS

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

1 YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

22a. I certify that (I) (this hospital) attended the deceased from

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|---|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Harding Pobloskie | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/6/81 | | 2b. HOUR 8:43P^{AM} | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 20 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 60 YRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH TOWSON MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman | | 12b. KIND OF BUSINESS OR INDUSTRY P&BR R.R. | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS 10 Waterview Road | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John S. Pobloskie | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Suzanna Runk | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II | | | | 16b. SOCIAL SECURITY NO. 181-14-4978 | | 17. INFORMANT ADDRESS Agnes D. Pobloskie Balto., MD. 21222 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) LARYNGEAL CA (METASTATIC) 1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 18 81 to NOV 6 81 , that (I) (we) last saw the deceased alive on NOV 6 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <i>for J. Kligman</i> | | | | DEGREE MD | | 22c. DATE SIGNED 11-6-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR J KLIGMAN | | | | 22e. ADDRESS GBMC | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland | | |
| 24. FUNERAL DIRECTOR Duda-Ruck, Inc. NAME 7922 Wise Avenue ADDRESS Dundalk, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. VanNathan</i> | | |

BP

11/18/81 10:43P

WILLIAM PORTSKIE

TOWSON

2001 N CHARLES ST GAITHERSBURG

BALTIMORE

RESIDENT ADDRESS

PREVIOUS

LYNNHILL CO (METASTATIC)

81

NOV 8

81

SEPT 11

81

NOV 8

GPIC

DR J KILIAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 3 5

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH B. POWERS, SR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-21-81 | | 2b. HOUR 9:15 AM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 10 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 69 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | |
| 10. CITY OR TOWN OF DEATH PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY BALMAR CORP. | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN GLYNDEN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 76 WAUGH AVE. | | 14. FATHER'S NAME FIRST MIDDLE LAST JAMES P. POWERS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE STROH | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | |
| 16b. SOCIAL SECURITY NO. 317-16-0189 | | 17. INFORMANT ADDRESS FAMILY RECORDS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-4 19 81 , to 11-21 19 81 , that (I) (we) last saw the deceased alive on 11-11 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Harold B. Bob M.D. | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-23-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD B. BOB M.D. | | 22e. ADDRESS 1320 PARK HEIGHTS AVE. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11/25/1981 | | 23c. NAME OF CEMETERY OR CREMATORY POPLAR GROVE | | 23d. LOCATION CITY OR TOWN COUNTY STATE COCKEYSVILLE BAL. CO. MD | |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES | | ADDRESS 2525 YORK RD | | 25a. DATE REC'D. BY REGISTRAR NOV 27 1981 | | 25b. REGISTRAR'S SIGNATURE James J. Martin | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 2 8 2 3 6 | |
|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LORETTA Q. PRITCHARD | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/28/81 | |
| 3. SEX Female | | 4. RACE White | | 2b. HOUR 10²⁰ P. | |
| 5. DATE OF BIRTH MONTH DAY YEAR 09 13 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) YES MONTHS DAYS 93 | | IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Baynesville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley View Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY Home | | 13a. STREET ADDRESS 1219 Baldwin Mill Road | | 13b. CITY OR TOWN Jarrettsville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Garland Quesenberry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Lusby | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 213-74-1355 | | 17. INFORMANT ADDRESS Margaret G. Chapman same as above | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) stroke with coma DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia @ side DUE TO, OR AS A CONSEQUENCE OF (c) CHF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 11/27/81 to 11/28/81 that (I) (we) last saw the deceased alive on 11/27/81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Nguyen ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED 11/30/81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NGUYEN | | 22e. ADDRESS 6 Linlow & Town Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/1/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Baltimore, Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 2 1981 | |
| 25b. REGISTRAR SIGNATURE | | | | | |

LAND OFFICE

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]



1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]
11. [illegible]
12. [illegible]
13. [illegible]
14. [illegible]
15. [illegible]
16. [illegible]
17. [illegible]
18. [illegible]
19. [illegible]
20. [illegible]
21. [illegible]
22. [illegible]
23. [illegible]
24. [illegible]
25. [illegible]
26. [illegible]
27. [illegible]
28. [illegible]
29. [illegible]
30. [illegible]
31. [illegible]
32. [illegible]
33. [illegible]
34. [illegible]
35. [illegible]
36. [illegible]
37. [illegible]
38. [illegible]
39. [illegible]
40. [illegible]
41. [illegible]
42. [illegible]
43. [illegible]
44. [illegible]
45. [illegible]
46. [illegible]
47. [illegible]
48. [illegible]
49. [illegible]
50. [illegible]
51. [illegible]
52. [illegible]
53. [illegible]
54. [illegible]
55. [illegible]
56. [illegible]
57. [illegible]
58. [illegible]
59. [illegible]
60. [illegible]
61. [illegible]
62. [illegible]
63. [illegible]
64. [illegible]
65. [illegible]
66. [illegible]
67. [illegible]
68. [illegible]
69. [illegible]
70. [illegible]
71. [illegible]
72. [illegible]
73. [illegible]
74. [illegible]
75. [illegible]
76. [illegible]
77. [illegible]
78. [illegible]
79. [illegible]
80. [illegible]
81. [illegible]
82. [illegible]
83. [illegible]
84. [illegible]
85. [illegible]
86. [illegible]
87. [illegible]
88. [illegible]
89. [illegible]
90. [illegible]
91. [illegible]
92. [illegible]
93. [illegible]
94. [illegible]
95. [illegible]
96. [illegible]
97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

F11m G614 Item 16a 4/28/86 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 2 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward C. Przybylski | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-14-81 | | 2b. HOUR 8:00a. M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 2, 1916 | | |
| 6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | 10. CITY OR TOWN OF DEATH Parkville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8832 Victory Ave. (Residence) | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Post Office | | 12b. KIND OF BUSINESS OR INDUSTRY Gov't. | | 13a. STREET ADDRESS Balt., Md. 21234 8832 Victory Avenue | | |
| 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Parkville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Casimer Przybylski | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Jaroszewska | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Wife: Teresa F. Przybylski ADDRESS Balt., Md. 21234 8832 Victory Ave. | | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4149 Arteriosclerotic Coronary Artery Disease IMMEDIATE CAUSE TO DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3-15 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) MAY | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8604 Harford Rd. Baltimore Maryland | | |
| 22a. I certify that (I) (the deceased) attended the deceased from MAY , 19 78 , to 11-14 , 19 81 , that (I) (we) last saw the deceased alive on 3-15 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Marion C. Kowalewski | | DEGREE MD | | 22c. DATE SIGNED 11-14-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marion C. Kowalewski, M.D. | | 22e. ADDRESS 8604 Harford Rd. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov 17 1981 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | |
| 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|---------------------|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) KATHERINE M. QUINN | | | 2a. DATE OF DEATH MONTH NOV. DAY 25 YEAR 81 | | 2b. HOUR 4:25 PM |
| 1. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH APR. DAY 21 YEAR 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 SLITTING MILL PL. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SR. CLERK | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN CATONSVILLE | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE F. LAST QUINN | | 15. MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE A. LAST MEEHAN | | 16. ADDRESS 201 SLITTING MILL PL. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-16-6359 | | 17. INFORMANT PATRICIA ANDRUCH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ESOPHAGEAL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORKING <input type="checkbox"/> ON <input type="checkbox"/> OFF <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from SEPTEMBER 3, 1981 to NOVEMBER 25, 1981 , that (1) (we) last saw the deceased alive on SEPTEMBER 3, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/27/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DIANA H. GRIEDER | | 22e. ADDRESS St. AGNES HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 11/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. CATONSVILLE | |
| 24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME ADDRESS EDMONDSON AVE | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 17 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

BP _____

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.



MADE IN THE U.S.A.
BY THE
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

MADE IN THE U.S.A.
BY THE
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

Item 5 g561 11/23/81 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 3 9

1 - STATE
REGISTRAR

REG. NO.

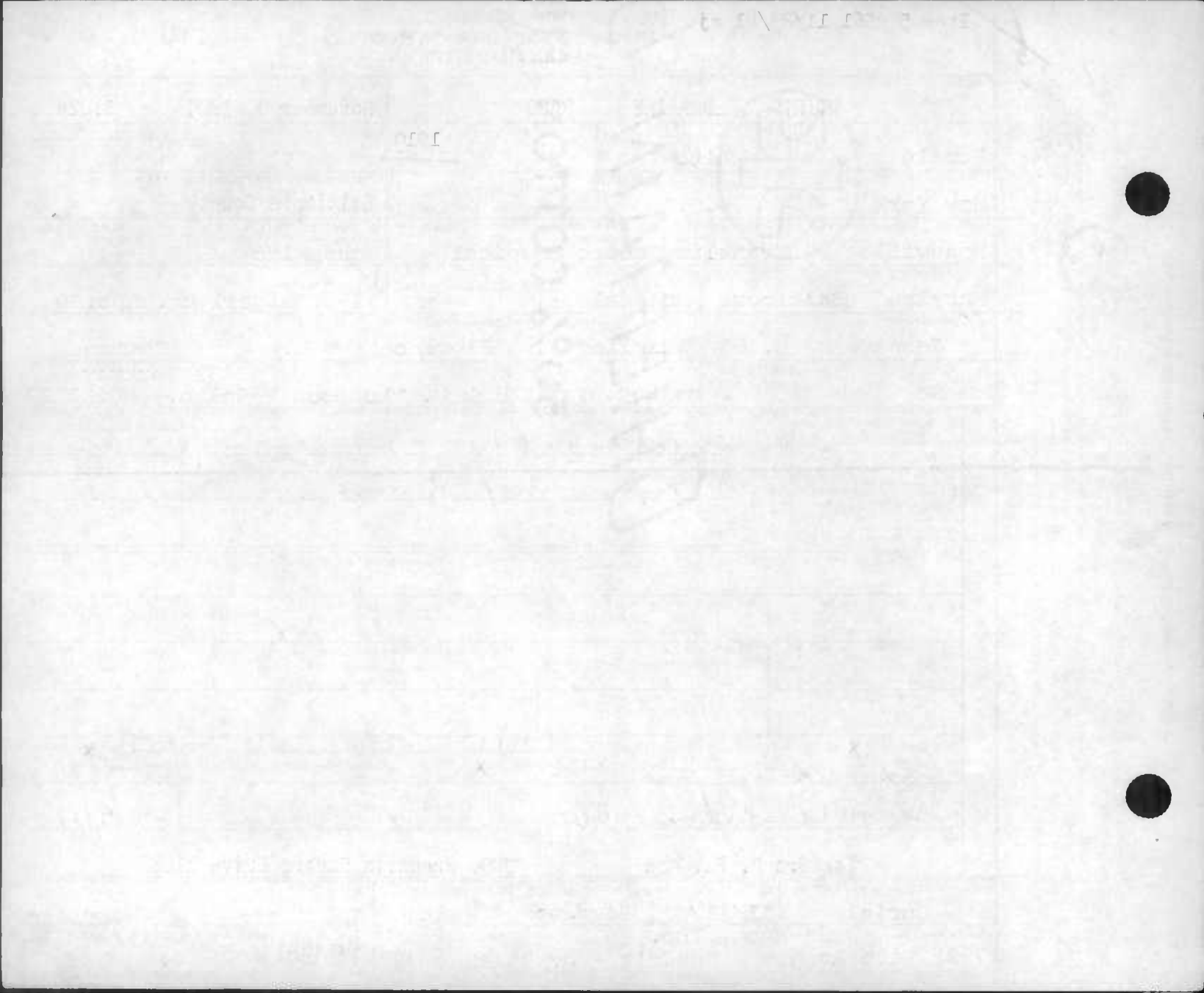
| | | | | | | | | | | |
|---|--|---|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) RUTH LORRAINE RADO | | | 2a DATE OF DEATH MONTH DAY YEAR November 9, 1981 | | | 2b HOUR 3:02a M | | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 2 19 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DATE HOURS MIN. | | |
| 7a BIRTHPLACE New York | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | |
| 10 CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | | | | 13b CITY OR TOWN Baltimore | | 13c CITY OR TOWN Rosedale | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Jesse B. Sterling | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence L. Seaman | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 096-05-2131 | | 17 INFORMANT ADDRESS Edith V. Thompson 3401 Yorkway Balto., MD. 21222 | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 5334 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Peptic Ulcer disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11/9</u> 19 <u>81</u> to <u>11/9</u> 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11/9</u> 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (I did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE Isadore A. Feldman, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 11/9/81 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Isadore A. Feldman | | | | | | 22e ADDRESS 9000 Franklin Square Drive 21237 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 11/11/81 | | 23c NAME OF CEMETERY OR CREMATORY Gardens Of Faith | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a DATE REC'D. BY REGISTRAR NOV 12 1981 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

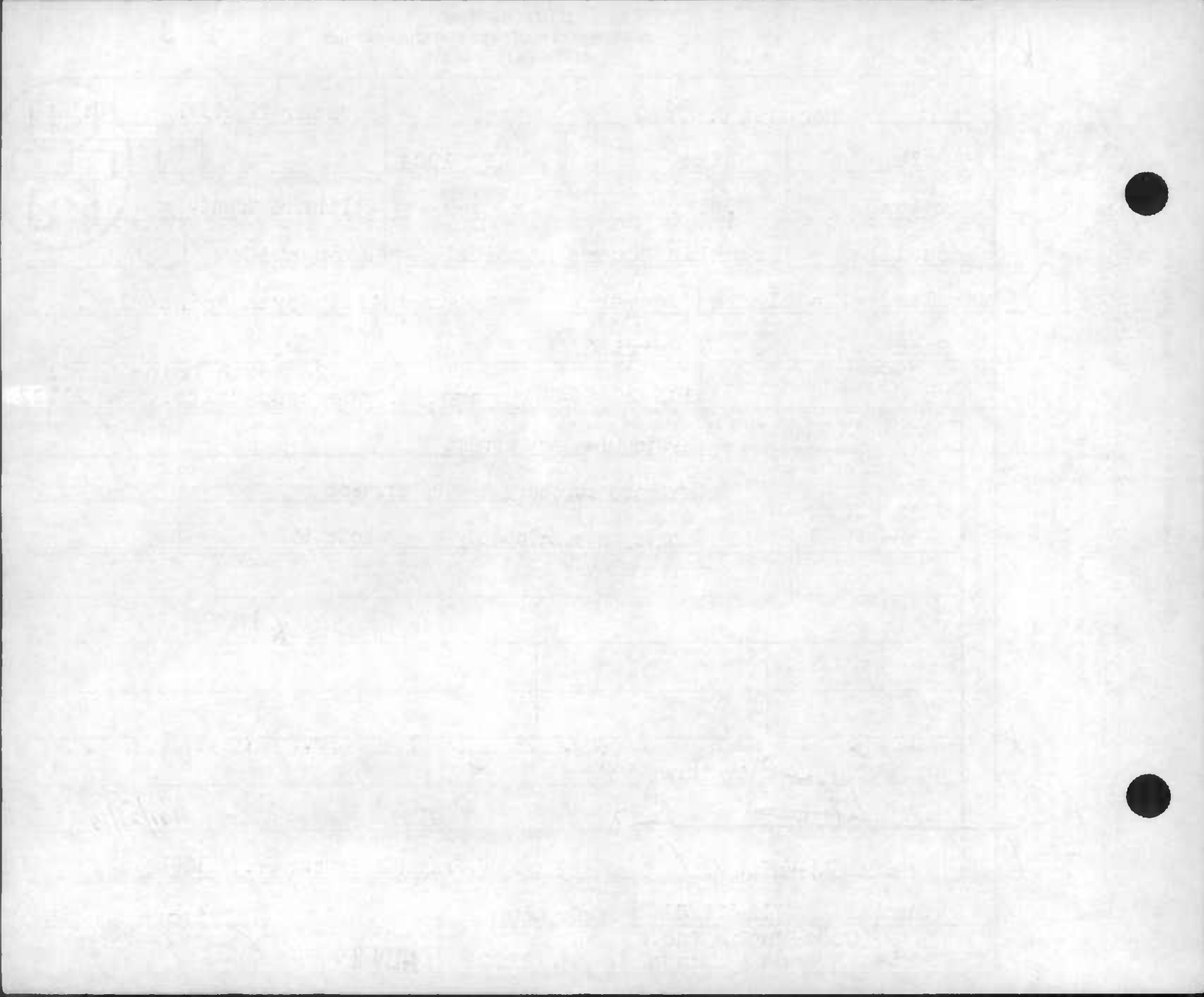
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 2 4 0

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Margaret D. RAMBO | | 2a. DATE OF DEATH MONTH DAY YEAR November 21, 1981 | | 2b. HOUR 6:40a M | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 9 22 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4528 North Point Blvd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George W. Merritt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella M. Thompson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | |
| 16b. SOCIAL SECURITY NO. 105-20-6049 | | 17. INFORMANT 4528 North Point Blvd. Margaret D. Robertson-Balto., MD. 21219 | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Advanced coronary artery disease (c) Anoxic encephalopathy Azotemia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from Aug. 19 19 81 to Nov. 21 19 81 that (we) lost saw the deceased alive on Nov. 21 19 81 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Haseeb Al-Mufti MD | | 22e. ADDRESS 9000 Franklin Square Dr., 21237 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR NOV 24 1981 | | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 81 28241 | | | |
|---|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALVIN RASKIN | | | | 2a DATE OF DEATH MONTH DAY YEAR NOVEMBER 18, 1981 | | 2b HOUR 7:40 A.M. | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR SEPT. 1, 1925 | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 56 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN | | 12b KIND OF BUSINESS OR INDUSTRY RETAIL | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c CITY OR TOWN MARYLAND BALTO. BALTIMORE | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 3311 WILD CHERRY RD. 21207 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL RASKIN | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HILDA HENKIN | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-NAVY 217-14-3507 | | 17 INFORMANT MRS. DORIS RASKIN 3311 WILD CHERRY RD. BALTO., MD 21207 | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-Respiratory Arrest 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE COPD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 12-1- 19 78 , to 11-18- 19 81 , that (I) (we) last saw the deceased alive on 11-18- 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Cesar V. Caverio DEGREE M.D. | | | | 22c DATE SIGNED 11-18-81 | | 22d PHYSICIAN'S NAME (TYPE OR PRINT) CEGAR V. CAVERIO | |
| 22e ADDRESS 5310 Old Et. Rd. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE NOV. 19, 1981 | | 23c NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25 DATE REC'D. BY REGISTRAR NOV 20 1981 REGISTRAR'S SIGNATURE James J. [Signature] | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) John FRANK | | 2a. DATE OF DEATH MONTH DAY YEAR November 30, 1981 | | 2b. HOUR 4:00 a.m. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 30, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Rossville 21237 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY National Can |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Essex | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Ratajczak | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mihalucki | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216 01 4704 | | 17. INFORMANT ADDRESS Catherine Ratajczak Same | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Circulation 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 or 6 days > 8 yr |
|--|--|--|

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|--|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/26, 1973 , to 11/30, 1981 , that (I) (we) last saw the deceased alive on 8/12, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE J. Blatti, M.D. | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 12/1/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. BLATTI, M.D. | | 22e. ADDRESS 406 Eastern Blvd. Balto 21224 | |

| | | | |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12-3-81 | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME Brazdzinski Funeral Home PA 1407 Old Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR DEC 3 1981 | 25b. REGISTRAR'S SIGNATURE [Signature] |



John Frank R. V.
1941

White

July 20, 1968

75

USA

Handwritten

Received from the American people

in recognition of

national day

100 years of the American people

x

100 years of the American people

John F. Kennedy

John F. Kennedy

100 years of the American people



100 years of the American people

100 years of the American people

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 28243 | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie M. PAVADGE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-11-81 | | 2b. HOUR 4:30 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 13 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 85 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Cr. MD | | | | | |
| 10. CITY OR TOWN OF DEATH Ruxton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Ruxton | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaking | |
| 13a. STATE Maryland | | 13b. COUNTY Sussex | | 13c. CITY OR TOWN Slaughter Beach | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 13e. STREET ADDRESS | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 221-16-4134 | | 17. INFORMANT ADDRESS 3206 Longwood Court Verna K. Lashley Jarrettsville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Cervix, Uterus cured 1809 DUE TO, OR AS A CONSEQUENCE OF (b) Paramecium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 30 October 1980 to 11-11-81, that (I) (we) lost the deceased alive on 11-11-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Walter T. Kees | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-11-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. KEES | | | | 22e. ADDRESS Monkton Md 21111 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11/13/81 | | 23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Milford Sussex Del. | | | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | | | 7401 Belair Road Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 13 1981 | | 25b. REGISTRAR'S SIGNATURE James J. Smith | |

MEDICAL CERTIFICATION

SECRET

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51



10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

10-10-51

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 4 4

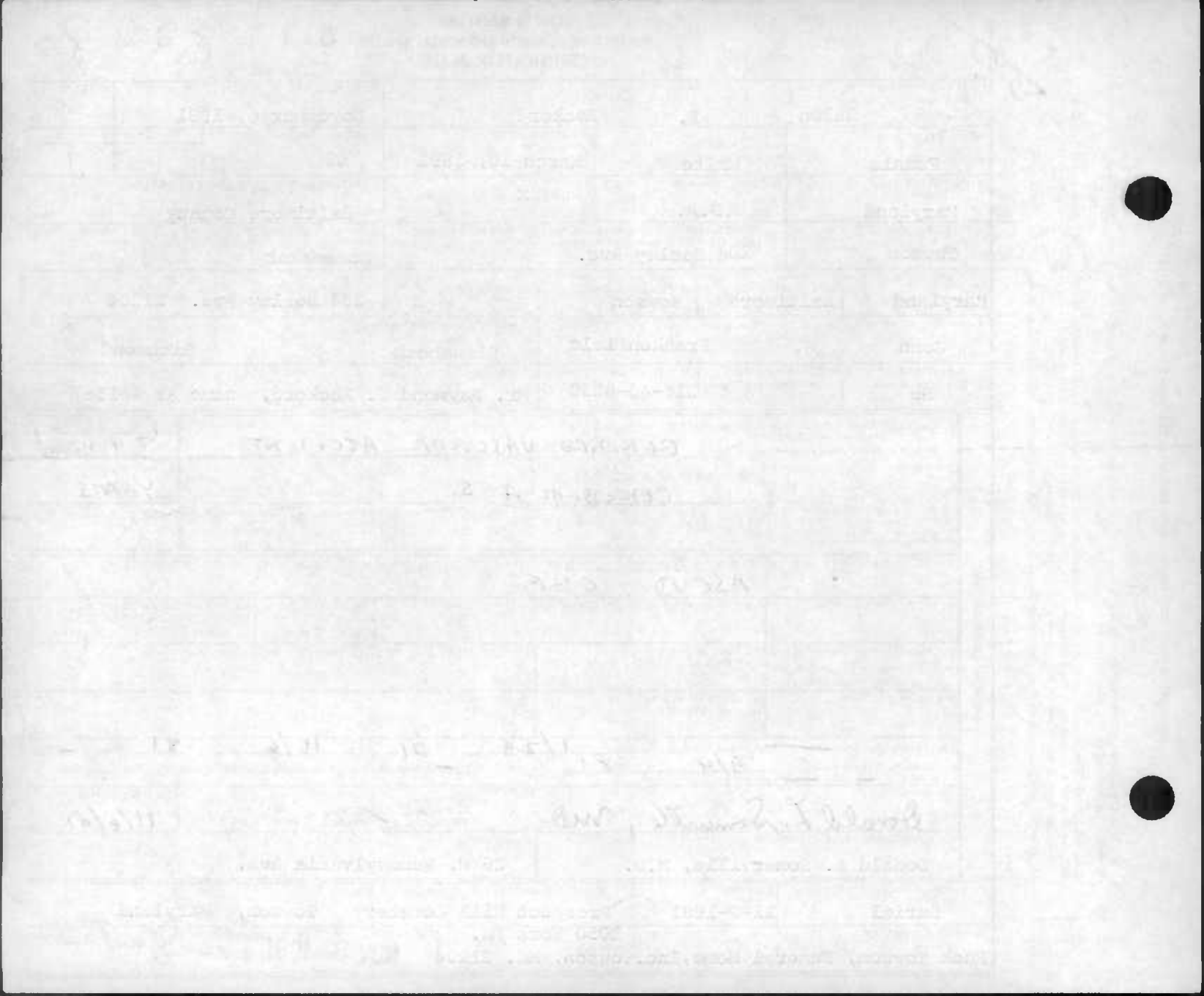
REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | |
| Helen F. Reckord | | November 6, 1981 | | M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 89 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Baltimore County MD | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Towson | 204 Bosley Ave. | | Homemaker | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | Baltimore | Towson | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 204 Bosley Ave. 21204 |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | |
| John W. Frankenfield | | | Elizabeth Richmond | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17 INFORMANT ADDRESS | | |
| No | | 216-46-6239 | Mr. Raymond C. Reckord, same as # 13e | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> 4360 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL A. S.</u> (c) <u>ASCVD, CHF.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS YEARS |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. | 19 | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | 21f. LOCATION | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11/29</u> 19 <u>71</u> to <u>11/6</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Donald L. Somerville, M.D.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | <u>11/6/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Donald L. Somerville, M.D. | | 26 W. Pennsylvania Ave. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | |
| Burial | | 11-9-1981 | Prospect Hill Cemetery | Towson, Maryland | |
| 24 FUNERAL DIRECTOR | | 1050 York Rd. | | 25a. DATE REC'D. BY REGISTRAR | |
| NAME ADDRESS | | Ruck Towson, Funeral Home, Inc. Towson, Md. 21204 | | NOV 9 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 4 5

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Henry W. Redlien | | | 2a. DATE OF DEATH MONTH DAY YEAR November 25, 1981 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR June 11, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Towson | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | 12b. KIND OF BUSINESS OR INDUSTRY Bendix Corp. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Towson | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 534 Valley View Rd. 21204 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Redlien, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane C. Kinder | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | 17. INFORMANT ADDRESS Mrs. Doris J. Redlien, same as #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SUPPEN DEATH DUE TO POSSIBLY MYOCARDIA INFARCTION</u> 4100 DUE TO, OR AS A CONSEQUENCE OF <u>EXERCISE INDUCED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>77</u> , to <u>10/30</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>10/30/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>Jamshid Hamed MD</i> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jamshid Hamed, M.D. | | | | 22e. ADDRESS 204 E. Joppa Rd. Towson, Maryland 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 11-27-81 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a legal director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

possible myocardial infarction
brought forward

General Hospital

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

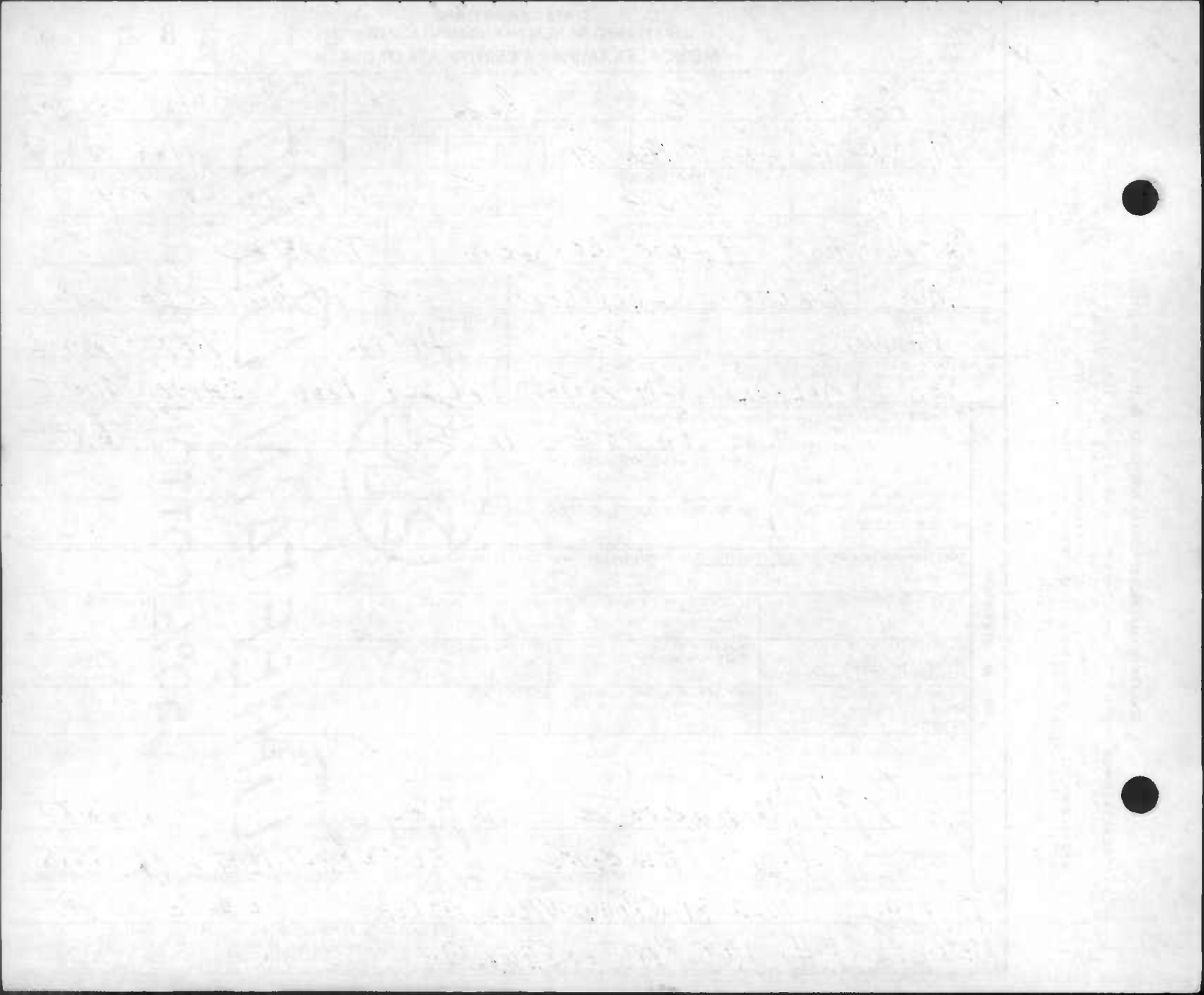
BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|----------------------|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ronald | | FIRST E. | | MIDDLE Reed | | LAST SR. | | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 11/28 1981 | | | | 2b. HOUR 5:50 PM | |
| 3. SEX M | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR AUG. 10, 1930 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 51 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 11/28 1981 | | 2d. HOUR 5:50 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HUSH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MD. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN GARRISON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 17 MONTROSE AVE. | | | | | |
| 14. FATHER'S NAME RAYMOND | | MIDDLE | | LAST REED | | 15. MOTHER'S MAIDEN NAME FIRST HELEN | | MIDDLE | | LAST ARMSTRONG | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 214-26-7623 | | 17. INFORMANT DeLia P. Reed | | ADDRESS SAME. 21055 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEUTE M.I. 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE E.P. Williamson | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 11/28/81 | | | | MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) E.P. Williamson | | | | ADDRESS 5550 BALTO. NAT'L PK 21228 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 12-2-81 | | 23c. NAME OF CEMETERY OR CREMATORY CROWNVILLE VET. CEM. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE A.A.-CO. MD. | | | |
| 24. FUNERAL DIRECTOR NAME NEWELL F.H. | | | | ADDRESS 1100 REISTERSTOWN RD. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 30 1981 | | | | 25b. REGISTRAR'S SIGNATURE James Van Nuthen | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 28247 | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NICHOLAS J. REGERT, JR | | | | | | | | | | 2b. DATE ESTIMATED MONTH DAY YEAR 11 15 1981 | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 22 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 74 | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 16 1981 | | 2d. HOUR M 2240 | |
| 10. CITY OR TOWN OF DEATH Dundalk | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6823 Duluth Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-Patapsco & | | 12b. KIND OF BUSINESS OR INDUSTRY B.R. R.R. | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6823 Duluth Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nicholas J. Regert, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Henning | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 705-10-9694 | | 17. INFORMANT Rose M. Regert | | ADDRESS 6823 Duluth Ave. Balto., MD. 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute intracerebral hemorrhage</u> 4310 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE J. Crossan O'Donovan | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 11/16/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN | | | | ADDRESS 2112 Dundalk Ave., Balto., Md. 21222 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11/20/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Rosary | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 19 1981 | | 25b. REGISTRAR'S SIGNATURE Name Jan [Signature] | | | |
| 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | | | | | | |



2038 COTTON FIBRE
MADE IN
INDIA

X X X X X

1911
The following is a list of the names of the persons who have been elected to the office of the President of the Indian National Congress for the year 1911.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 2 8 2 4 8 | |
|---|--|---|---|--|--|---|---|---|---|---------------|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) John Henry Reider | | | | | 2a DATE OF DEATH MONTH DAY YEAR 11 05 81 | | | 2b HOUR 5:00 PM | | | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR 02 05 05 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8b CITIZEN OF WHAT COUNTRY? USA | | 9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Satto Co. MD | | | | | |
| 10 CITY OR TOWN OF DEATH Yowson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruston | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plasterer | | 12b KIND OF BUSINESS OR INDUSTRY self-employed | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland 13c COUNTY Baltimore 13d CITY OR TOWN Fullerton | | | | | 13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13f STREET ADDRESS 7909 Belair Road 21236 | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Fred Reidner | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Besold | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b SOCIAL SECURITY NO. 215-22-1353 | | 17 INFORMANT ADDRESS Lois I. Berg 4039 Joppa Road 21236 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7-24 , 19 81 , to 11-5 , 19 81 , that (I) (we) last saw the deceased alive on 11-5 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Walter T. Kees MD | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED 11-5-81 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. KEES | | | | | 22e ADDRESS Monkton MD 21111 | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 11/9/81 | | 23c NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d LOCATION CITY OR TOWN COUNTY STATE Overlea Baltimore Md. | | | | | |
| 24 FUNERAL DIRECTOR NAME Hasseck P/H | | | | | ADDRESS 74017 Belair Rd | | 25a DATE REC'D. BY REGISTRAR NOV 9 1981 | | 25b REGISTRAR'S SIGNATURE James J. K... | | |

11-22-81

John R. ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES MELVIN REISENWEBER | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 04 '81 | | | 2b. HOUR 12:50A | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 5 11 '08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance | | 12b. KIND OF BUSINESS OR INDUSTRY --- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Cockeysville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8 Warren Lodge Court | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles NMN Reisenweber | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Litezta Weisner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-05-1751 | | 17. INFORMANT ADDRESS 8 Warren Lodge Ct Margaret B. Reisenweber, Cockeysville Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) INTERCEREBRAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (c) STROKE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 78 HOURS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-30 19 81 , to 11-04 19 81 , that (I) (we) last saw the deceased alive on 11-04 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Brian Adler | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 11/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN ADLER, M.D. | | | | 22e. ADDRESS GBMC-6701 N. CHARLES ST. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/6/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto Md. | | | |
| 24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon | | | | ADDRESS 10 W. Padonia Rd | | 25a. DATE REC'D. BY REGISTRAR NOV 5 1981 | | 25b. REGISTRAR'S SIGNATURE Thane | |

BP

11 04 191 13-50A

CHARLES, A.M. REISENBERG

73

11 197

5

WHITE

MALE

BALTIMORE COUNTY

22 279AND N. CHARLES ST

TOWSON

RESPIRATORY FAILURE

INTERCEREBRAL BLEEDING

STROKE

X

81

11-01

81

10-30

81

11-01

22 279AND N. CHARLES ST

BRIAN ADLER, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 2 8 2 5 0 | |
|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM HAROLD REMMEY | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 10, 1981 | | 2b. HOUR 11:55pm |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 16, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 603 1/2 JEFFREY STREET | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William G. Remmey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Pfeiffer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 212 07 6739 | | 17. INFORMANT ADDRESS Anne Remmey same as 13 e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA TO BONES AND KIDNEY 1629 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } ADENO CARCINOMA, LEFT LUNG gave rise to immediate } cause (a), stating the } underlying cause last. } (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 3 MONTHS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a CEREBROVASCULAR ACCIDENT, SEIZURE DISORDER | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 10/13 , 19 81 , to 11/10 , 19 81 , that (we) last saw the deceased alive on 11/10 , 19 81 , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Aurora C. Tan M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 11/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AURORA C. TAN, M.D. | | | | 22e. ADDRESS VAMC, FORT HOWARD, MARYLAND 21052 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Brooklyn A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce Balto. Md. 21225 ADDRESS 4001 Ritchie Hgwy | | | | 25a. DATE RECEIVED BY REGISTRAR NOV 17 1981 REGISTRAR'S SIGNATURE <i>Thane J. G. [Signature]</i> | |

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

NOV 1 1961

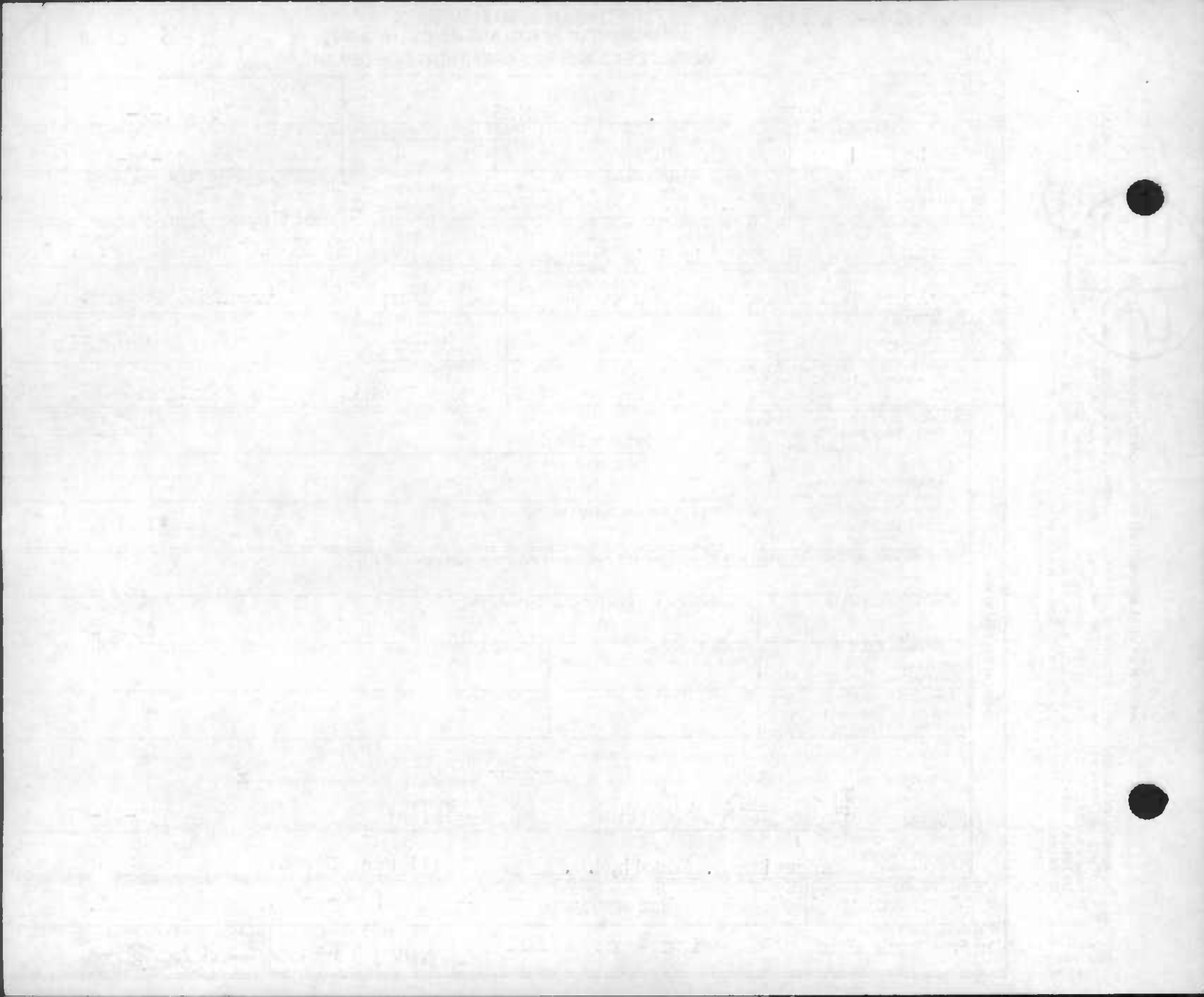
NOV 1 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M2/80

| Items #18a-22a Film G562 12/28/81 STATE OF MARYLAND | | | | | | | | | | |
|--|---------|--|---|---|---|--|--|---|--|----------|
| 1- STATE REGISTRAR | | | | | | | | | | |
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 28251 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE KNOWN OF DEATH | | | | | 2b. HOUR |
| EVELYN D. RHINE | | | | | MONTH DAY YEAR 11-3-81 | | | | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) LAST BIRTHDAY | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | |
| female | White | 7 13 28 | 53 | | | 11-10-81 | | 5PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | 500 Virginia Avenue | | | | Claims Adjuster | | S.S. Adm. | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| Maryland | | Baltimore | | Towson | | 13e. STREET ADDRESS 500 Virginia Towers | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Elmer C. Stehli | | | | | Mary Hanafin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | 217-24-3348 | | Elmer Stehil -1719 Kirkland Rd. 2122 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Undetermined</u> | | | | | | | | | | |
| 7999 { DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE | | | | |
| <i>Margarita A. Korell</i> | | | Assistant | | | 11-11-81 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | MEDICAL EXAMINER SIGNED | | | | |
| Margarita A. Korell, M.D. | | | 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | | 11/14.81 | | Greenmount Cemetery | | Balto. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Duda-Ruck Inc. 7922 Wise Ave. 21222 | | | | | NOV 19 1981 | | <i>James J. [Signature]</i> | | | |



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

81 28252

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA SCOTT RICHARD | | | 2a. DATE OF DEATH MONTH DAY YEAR NOV. 25 81 | | 2b. HOUR M |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR JULY 29 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOUSE IN THE PINES | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. COUNTY BALTO. | 13c. CITY OR TOWN CATONSVILLE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSHUA W SCOTT | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA MCCANN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 020-343849 | | 17. INFORMANT ADDRESS PAUL R. RICHARD 120 MALBROOK RD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimers Disease 3310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Probable Spleenemia | | | | | |
| 19a. DATE OF OPERATION 11/29/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Probable Spleenemia | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1976 , to 11/25 81 , that (I) (we) last saw the deceased alive on 10/30 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE J. Nolan | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/27/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JAMES NOLAN | | 22e. ADDRESS MALLOW HILL RD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11/28/81 | | 23c. NAME OF CEMETERY OR CREMATORY WOODLAWN | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD. | | 23e. DATE REC'D. BY REGISTRAR DEC 1 1981 | | | |
| 24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME | | ADDRESS EDMONDSON AV 5311 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | |
|--|--|---|--|---|--|--|---|-----------------------------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | |
| MARY R. RICHARDSON | | | | | NOVEMBER 15 1981 | | | | | 3:58 P.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | | |
| Female | | White | | Jan. 7, 1893 | | 88 YRS | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Missouri | | USA | | | | Baltimore County MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Lutherville | | College Manor Nursing Home | | | | Teacher | | Education | | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| Maryland | | | | | | | Baltimore | | 230 Stony Run Lane | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Dr. William F. Rienhoff | | | | | Sadie A. Hopkins | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | | 217 20 0570 | | William R. Richardson, Towson, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 7 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 8 months | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumonia | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| NONE | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NO ACCIDENT | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1977, 19, to November 15, 1981, that (I) (we) last saw the deceased alive on Nov 13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Charles E. Ellicott M.D. | | | | | DEGREE M.D. | | | | | 22c. DATE SIGNED Nov 15 '81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES E. ELLICOTT M.D. | | | | | 22e. ADDRESS 1134 York Rd 21093 Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Cremation | | | | | 11/16/81 | | Green Mount | | | Balto., Md. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | NOV 16 1981 | | | | | Randy J. [Signature] | | | | |

SEE York Road, Md. 21212
Henry W. Jenkins & Sons Co.

11 Ford Green Mount

Baltimore

11 Ford Green Mount

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

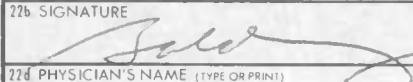

Baltimore

Baltimore

Baltimore

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 5 4

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| FIRST MIDDLE LAST Darwin W. Riden | | | | | | MONTH DAY YEAR November 18, 1981 | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 74 HRS | |
| Male | | White | | MONTH DAY YEAR August 9, 1916 | | 65 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | | U. S. A. | | | | Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Monkton | | 2306 Monkton Road | | | | Executive Vice Pres. | | Williams | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | | |
| 13a. STATE COUNTY Maryland Baltimore | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2306 Monkton Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter H. Riden | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Detra | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | | 717-09-4042A | | Mrs Theda May Riden, Same As #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE  | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan J. Baldanza M.D. | | | | | | 22e. ADDRESS 10629 York Road, Cockeysville, Md. 21030 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11-21-81 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. | | | | 1050 York Rd. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE NOV 23 1981  | | | |

IMPORTANT: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on 1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on 1.



REPRODUCTION

Items #18a-22a Film G561 11/10/81r STATE OF MARYLAND
 FOR Item #5 Film G561 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1- STATE REGISTRAR 2/23/82 rc MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28255

| | | | | | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|-------------------------|--|--|----------------|------------------|--|---|--|----------|--|-----------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | | | | | |
| WILLIAM HENRY ROBERTS, JR. | | | | | | 10 26 19 81 | | | | | | M | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | |
| Male | | White | | 9 5 81 | | YRS. 1 21 | | MONTHS DAYS | | HOURS MIN. | | 10 26 19 81 | | 6:30 a M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Dundalk | | | | 71 Admiral Blvd. | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| Maryland | | | | BALTIMORE | | | | Baltimore | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 2119 Frederick Avenue 21223 | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| William H. Roberts, Sr. | | | | | | | | Theresa Gigaigialo | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| NO | | | | | | | | ---- | | | | 21223 William H. Roberts, Sr. 2119 Frederick Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: Sudden infant Death Syndrome | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 7980 | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | DATE SIGNED | | | | | | | |
| Thomas D. Smith | | | | M.D. Deputy Chief | | | | | | | | 10/26/81 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| Thomas D. Smith, M.D. | | | | 111 Penn St. Balto., MD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Burial | | | | 10/28/81 | | | | Glen Haven Cemetery | | | | Glen Burnie A.A. Co. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Balto., Md. 21229 | | | | | | | | OCT 30 1981 | | | | Thane Jan. Martin | | | | | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | | | | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 5 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|--|---------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) SAMUEL ROLL | | | 2a DATE OF DEATH MONTH DAY YEAR NOVEMBER 24, 1981 | | 2b HOUR 4:30 PM | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR OCT. 14, 1904 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | 10 CITY OR TOWN OF DEATH RANDALLSTOWN | | |
| 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3501 BEAGLE LANE APT. 102(21133) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFER | | 12b KIND OF BUSINESS OR INDUSTRY TAXI CAB | | |
| 13a STATE MARYLAND | | 13b COUNTY BALTIMORE | | 13c CITY OR TOWN RANDALLSTOWN | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST MOSES ROLL | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH KEMPER | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | |
| 16b SOCIAL SECURITY NO. 055-05-99050 | | 17 INFORMANT ADDRESS MRS. MARILYN ROLL 3501 BEAGLE LANE APT. 102 (21133) | | 18 CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction (A.S.C.D.) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.D. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:24 P.M. 19 | | 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | |
| 21a INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) this hospital attended the deceased from 11/24 19 81 to 11/24 19 81 , that (I) viewed the deceased alive on 11/24 19 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) viewed (did) not view the body after death. | | | | | | |
| 22b SIGNATURE Robert Kroopnick DEGREE MD | | | | 22c DATE SIGNED 11/25/81 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KROOPNICK | | | | 22e ADDRESS 8726 LIBERTY RD. (21133) | | |
| 23a BURIAL, CREMATION, REMOVAL BURIAL | | 23b DATE 11/25/81 | | 23c NAME OF CEMETERY OR CREMATORY BETH TFILOH | | |
| 23d LOCATION WOODLAWN, MD. COUNTY MD STATE MD | | 23e DATE REC'D. BY REGISTRAR 23f REGISTRAR'S SIGNATURE DEC 1 1981 Frances Jan. Nathan | | | | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1. The first part of the report is a summary of the work done during the period covered by the report.

2. The second part of the report is a detailed account of the work done during the period covered by the report.

3. The third part of the report is a summary of the work done during the period covered by the report.

4. The fourth part of the report is a summary of the work done during the period covered by the report.

5. The fifth part of the report is a summary of the work done during the period covered by the report.

6. The sixth part of the report is a summary of the work done during the period covered by the report.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|------------------|-------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| DAVID | | November 17, 1981 | | 8 1/2 M. | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| MALE | WHITE | MONTH DAY YEAR | 70 YRS. | IF UNDER 24 HRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| PENNSYLVANIA | USA | | BALTIMORE COUNTY MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS OR INDUSTRY | | |
| RANDALLSTOWN | BALTIMORE COUNTY GEN. HOSP. | CHAUFFEUR | TRUCKS | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a INSIDE CITY LIMITS? | 13b STREET ADDRESS | | |
| 13a STATE | 13b COUNTY | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | #21207 | | |
| MARYLAND | BALTO. | | 3510 LANGREHR RD., APT. G | | |
| 14 FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | |
| ISAAC ROSENWEIG | SARAH TUCKER | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17 INFORMANT | | | |
| YES | WWII-ARMY | MRS. IRENE ROSENWEIG | | | |
| | 213-01-2474 | 3510 LANGREHR RD., APT. G | #21207 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | |
| (b) <u>PSYCHOP.</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| <u>Kidney Stone</u> | | | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>11/17/81</u> 19 <u>81</u> to <u>11/17</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>11/17</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death. | | | | | |
| 22b SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | |
| <u>Robert K. Cropper, M.D.</u> | <u>M.D.</u> | | | <u>11/18/81</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | 22e ADDRESS | | | | |
| <u>Robert K. Cropper, M.D.</u> | <u>8726 L. Bed St. #620 Mall.</u> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN | COUNTY | STATE |
| BURIAL | NOV. 19, 1981 | FORBAND | ROSEDALE | BALTO. | MD |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE | | |
| | | | <u>NOV 20 1981</u> <u>[Signature]</u> | | |

BP

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 3, 7a g561 11/13/81 gj

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 5 8

REG. NO.

| | | | | | |
|--|---|--|---|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) SIDNEY L. ROSSITER | | | 2a DATE OF DEATH MONTH DAY YEAR November 3, 1981 | | 2b HOUR 3:00A _M |
| 3 SEX Female Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR June 11, 1901 | 6 AGE (IN YEARS, LAST BIRTHDAY) 80 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD | | |
| 10 CITY OR TOWN OF DEATH 21234 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway Nursing Home | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | 12b KIND OF BUSINESS OR INDUSTRY Construction | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | 13b COUNTY Baltimore | 13c CITY OR TOWN 21234 | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS 1721 Aberdeen Road |
| 14 FATHER'S NAME FIRST MIDDLE LAST Alexander Rossiter | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice McDonald | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II | 17 INFORMANT ADDRESS Gail Johnson Baltimore, MD 21234 | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Age</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Gracito Patricio</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 11/3/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Gracito Patricio, M.D. | | 22e ADDRESS 2926 E. Cold Spring Lane 254-0392 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b DATE Nov. 4, '81 | 23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD | | |
| 24 FUNERAL DIRECTOR NAME William E. Johnson | | ADDRESS 8521 Loch Raven Blvd. | | 25a DATE REC'D. BY REGISTRAR NOV 3 1981 | 25b REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> |

RECEIVED

RECEIVED
MAY 14 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 5 9

REG. NO.

| | | | | | |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Theima M. Rudasill | | 11 9 81 | | 1115 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Female | White | May 2, 1924 | 57 | Baltimore County MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Maryland | U.S.A. | | Homemaker | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Randallstown | Baltimore County General Hospital | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Baltimore | Woodlawn | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 7321 Elmore Avenue 21207 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| Henry Triplett | Marie Deitz | No | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| 218-22-6503 | | Mr. Maurice O. Rudasill | | | |
| | | 7321 Elmore Avenue Balto. MD. 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>retastated carcinoma of the lung</u> 1629 | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Myocardial infarction</u> | | | | | |
| (c) <u></u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/11/81</u> 19 <u>81</u> to <u>11/9</u> 19 <u>81</u> , that (I) (we) lost <u>10/19</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Robert L. Goodnick | | MD | | 11/9/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Robert L. Goodnick MD | | 8126 Liberty Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 11/13/81 | | St. Johns Cemetery | |
| 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Randallstown | | Howard | | Maryland | |
| 24. FUNERAL DIRECTOR | | 25. DATE RECD. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | |
| Loring Byers Funeral Directors, Inc. | | NOV 10 1981 | | [Signature] | |
| 8728 Liberty Road Randallstown, MD. 21133 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|---|--|-----------------------------|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNARD ALBERT RUOCO, SR. | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 29, 1981 | | 2b. HOUR 2:20 A.M. | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 8, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker | | 12b. KIND OF BUSINESS OR INDUSTRY Real Estate | | | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 302 E. Joppa Road, Apt. 801 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Ruocco | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Toschi | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 139-12-6913 | | | 17. INFORMANT ADDRESS Mrs. Alice S. Ruocco 302 E. Joppa Road | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sudden death (by description)</u> 4149 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) <u>attended</u> the deceased from <u>January</u> , 19 <u>76</u> , to <u>date</u> , 19 <u>81</u> , that (I) <u>last</u> saw the deceased alive on <u>9-16-</u> 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Dennis Gulin MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 11/30/81 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis G. Caralis, M.D. | | | | | 22e. ADDRESS 660 Kenilworth Drive | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12-2-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley 1050 York Road | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | | | | ADDRESS Towson, Maryland | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] | | | | | | | |

BP _____



11/26/51

DEC 28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 6 1

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) MADELINE M RUOFF | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 29, 1981 | | 2b. HOUR 9:33P M |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 10 30 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY Ice Cream Co. |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN Baltimore | 13c. STREET ADDRESS 3338 Kenyon Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Koch | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Carroll | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 218-12-4349 | | 17. INFORMANT ADDRESS Ralph Ruoff 3338 Kenyon Ave. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: **CEREBROVASCULAR ACCIDENT**

4360

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

MEDICAL CERTIFICATION

| | | | |
|---|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov 6, 1981 , to Nov 29, 1981 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov 29, 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.) | | | |
| 22a. SIGNATURE Alvin L. Brewer | | 22b. ADDRESS 7620 York Rd. Balt. MD 21204 | 22c. DATE SIGNED 11/29/81 |
| 22d. DEGREE M.D. | | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12/3/81 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 23d. LOCATION CITY OR TOWN COUNTY STATE Balt. MD |
| 24. FUNERAL DIRECTOR NAME Holy Land | | 24b. ADDRESS 4210 Belair Rd. | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 |
| | | 25b. REGISTRAR'S SIGNATURE Ralph Ruoff | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 fully be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.



RECEIVED

NOV 20 1951

NOV 20 1951

RECEIVED

NOV 20 1951

NOV 20 1951

RECEIVED

NOV 20 1951

NOV 20 1951

Handwritten notes and signatures at the bottom of the page, including "Mr. J. B. Brown" and "J. B. Brown".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 6 2

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST MARIE J. RUTH | | MONTH DAY YEAR 11-8-81 | |
| 3 SEX | | 2b. HOUR | |
| Female | | 12:40 P.M. | |
| 4 RACE | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| White | | 65 YRS. | |
| 5. DATE OF BIRTH | | IF UNDER 1 YEAR | |
| MONTH DAY YEAR 02-21-16 | | MONTHS DAYS | |
| 7a. BIRTHPLACE (COUNTRY) | | IF UNDER 24 HRS | |
| BALTO. MARYLAND | | HOURS MIN. | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| USA | | Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | Housewife | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| St. Agnes Hospital | | --- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13e. STREET ADDRESS | |
| 13a. STATE | | 2101 Edmondson Ave | |
| 13b. COUNTY | | 13d. INSIDE CITY LIMITS? | |
| Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13c. CITY OR TOWN | | 15. MOTHER'S MAIDEN NAME | |
| Catonsville | | FIRST MIDDLE LAST | |
| 14. FATHER'S NAME | | Anna Rachuba | |
| FIRST MIDDLE LAST | | 17. INFORMANT ADDRESS | |
| Karlol Greeki | | 2101 Edmondson Ave, Catonsville, Md. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17. INFORMANT ADDRESS | |
| No | | 2101 Edmondson Ave, Catonsville, Md. | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 21228 | |
| --- | | 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>carcinomatosis</u> | | | |
| 1579 DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) <u>cancer Pancreas</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) <u>---</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| July 81 | | Ca Pancreas | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | |
| | | P.M. --- 19 --- | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION | | CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>10-24-1981</u> to <u>11-8-1981</u> that (we) last saw the deceased alive on <u>11-8-1981</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | |
| <u>[Signature]</u> | | M.D. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| R.D. ARORA | | 22c. DATE SIGNED | |
| | | 11.8.81. | |
| 22e. ADDRESS | | | |
| St. Agnes Hospital, Balto. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Burial | | 11/11/81 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Druid Ridge Cem. | | Balto. COUNTY STATE | |
| | | Md. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | |
| Attending Funeral Director | | NOV 12 1981 | |
| 736 Edmondson Ave. ADDRESS | | 25b. REGISTRAR'S SIGNATURE | |
| Catonsville, Md. 21228 | | <u>[Signature]</u> | |

BP

200V POLICE LINE

11-2-81 10-11

MADE 2

10-11-81

10-11-81

10-11-81

10-11-81

10-11-81



10-11-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 2 8 2 6 3 | | | |
|--|--|--|--|--|--|--|--|--|--|---|-----------|---|----------------------|
| 1 - FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST WILLIAM | | MIDDLE HENRY | | LAST RYAN | | 2a DATE OF DEATH | | MONTH 11 | DAY 12 | YEAR 81 | 2b HOUR 7:40 M |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH 7 DAY 15 YEAR 00 | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 8 IF UNDER 24 HRS HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired President | | 12b KIND OF BUSINESS OR INDUSTRY Teamsters | | | | | |
| 13a STATE Maryland | | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14 FATHER'S NAME FIRST William | | MIDDLE Henry | | LAST Ryan, Sr. | | 15 MOTHER'S MAIDEN NAME FIRST Sara | | MIDDLE Cook | | LAST Cook | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212032547A | | 17 INFORMANT ADDRESS Mrs. Lillian G. Ryan 1524 Waverly Way | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Antibiotic pneumonia origin</u> 1991 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>asev</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>81</u> , to <u>11/12</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Daniel Wilfson</u> | | | | | | | | DEGREE | | 22c. DATE SIGNED <u>11/12/81</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Wilfson, M.D. | | | | | | | | 22e. ADDRESS 3502 W. Rogers Avenue | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11-14-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | | | 23d. LOCATION CITY OR TOWN Baltimore | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Maryland | | | | 1050 York Road ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR NOV 16 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | |
| 26. DATE REC'D. BY REGISTRAR NOV 16 1981 | | | | 26b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | | | | | | | |

22

1/10/20

22

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|---------------------------|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LESTER SALLERSON | | | 2a DATE OF DEATH MONTH DAY YEAR Nov 9, 1981 | | 2b HOUR 10 A.M. | | | | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR OCT. 2, 1912 | | 6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS NO | | 8 IF UNDER 74 HRS HOURS MIN. NO | |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 9b CITIZEN OF WHAT COUNTRY? USA | | 10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | | | | | |
| 10 CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COUNTER MAN | | 12b KIND OF BUSINESS OR INDUSTRY DELICATESSEN | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY BALTO. 13c CITY OR TOWN BALTIMORE | | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 3454 VARGAS CIR. #21207 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL SALLERSON | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA UNKNOWN | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATE) WWII-ARMY 128-09-9972 | | 17 INFORMANT ADDRESS MRS. FLORENCE SALLERSON | | | | 3454 VARGAS CIR., APT. 2A #21207 | | | |

| | | | |
|--|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Arteriosclerotic Heart Disease 4 years | |
| (c) diabetes mellitus | | | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Jan 2, 1968 to Nov 9, 1981 , that (I) (we) lost saw the deceased alive on OCT 21, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Manuel Levin M.D. | | | | DEGREE M.D. | | 22c DATE SIGNED Nov 9/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D. | | | | 22e ADDRESS 6101 PK Hts Ave Balto MD 21215 | | | |

| | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE NOV. 11, 1981 | | 23c NAME OF CEMETERY OR CREMATORY PETACH TIKVAH | | 23d LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | 25a DATE REC'D. BY REGISTRAR NOV 16 1981 | | 25b REGISTRAR'S SIGNATURE James J. [Signature] | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

Nov 11/21

RECEIVED

11/11/21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | 8 1 2 8 2 6 5 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Betty L. Sanders | | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 26, 1981 | | 2b. HOUR 3:45p M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 8 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Rossville 21237 | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Custodian | | 12b. KIND OF BUSINESS OR INDUSTRY Apartment Project | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Essex 21221 | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 13 "B" Westway North | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William O'Grady | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude A. Suttueth | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220 22 3757 | | 17. INFORMANT ADDRESS Paul E. Sanders, Husband | | | Same | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli, Bilateral 4151 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } b) _____ c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 26, 1981 to November 26, 1981 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 26, 1981 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert L. Lyles DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/26/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Lyles, M.D. | | | | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/30/81 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md. | | | |
| 24. FUNERAL HOME Bruzdzinski Funeral Home PA 1407 Old Eastern Ave | | | | | 25. DATE REC'D BY REGISTRAR NOV 30 1981 | | 26. REGISTRAR'S SIGNATURE James J. [Signature] | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 6 6

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Mary A. Sanzone | | 2a. DATE OF DEATH MONTH DAY YEAR November 16, 1981 | | 2b. HOUR M | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 27, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Colgate | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7274 Conley Street (Residence) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Colgate | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Balt., Md. 21224 7274 Conley Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur Brown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Not Known | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 056-12-1808 | | 17. INFORMANT Daughter: Address Balt., Md. 21224 Kathy O'Halloran 7274 Conley Street | | | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 18, 1981, to Nov 16, 1981, that (I) (we) lost saw the deceased alive on Nov 15-81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard E. Fisher | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/18/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Fisher, M.D. | | 22e. ADDRESS 4700 Pennington Ave. Balto. Md. 21226 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov 20 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | ADDRESS Balt., Md. 5305 Harford Rd. | | 25a. DATE REC'D. BY REGISTRAR NOV 19 1981 | | 25b. REGISTRAR'S SIGNATURE Anne Jan... | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

1910

U.S.A.

Form

Column

(last name)

House

Address

Belmont

Column

X

1910

Address

House

Column

1910

Column

1910

1910

1910

1910



1910

1910

1910

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|---|-----------------------------------|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna Catherine Sause</i> | | | | | 2a DATE OF DEATH MONTH DAY YEAR <i>11 11 81</i> | | | | | 2b HOUR <i>10^{PM}</i> |
| 3 SEX <i>Female</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>8 26 03</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>78</i> | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD | | | | |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3709 Coronado Road</i> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>-</i> | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 13a STATE <i>MD</i> | | 13b COUNTY <i>Baltimore</i> | | 13c CITY OR TOWN <i>Baltimore</i> | | 13e STREET ADDRESS <i>3709 Coronado Road</i> | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Henry Otto Hellmig</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Wagner</i> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b SOCIAL SECURITY NO. <i>215-16-9743</i> | | 17 INFORMANT ADDRESS <i>Mr. Frederick J. Sause 3709 Coronado Rd., Baltimore, MD 21207</i> | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>ASVD</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <i>-</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>10 yr -</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>nm</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>2:00 11/11 81</i> P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/30</i> , 19 <i>74</i> , to <i>11/11</i> , 19 <i>81</i> that (I) (we) last saw the deceased alive on <i>11/11</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Maurice Feldman</i> | | | DEGREE <i>MD</i> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>11/12/81</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PR MAURICE FELDMAN JR</i> | | | 22e. ADDRESS <i>6610 CROSS COUNTRY BLVD.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>11/14/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Parkville Baltimore MD</i> | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors 8728 Liberty Rd., Randallstown, MD 21133</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>NOV 13 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. Nathan</i> | | |

MEDICAL CERTIFICATION

20% COL-00X-111

11/11/11

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALH L. SCHELLER | | | 2a DATE OF DEATH MONTH DAY YEAR NOV. 24 1981 | | | 2b HOUR M | |
| 3 SEX M | | 4 RACE W | | 5 DATE OF BIRTH MONTH DAY YEAR 10/7/14 | | 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH SPARROWS PT. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7338 WALDMAN | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PEN. CO | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE MD. | | | | 13b COUNTY BALTO | | 13c CITY OR TOWN SPARROWS PT | |
| 14 FATHER'S NAME FIRST MIDDLE LAST GEORGE SCHELLER | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK | | 16b SOCIAL SECURITY NO UNK | | 17 INFORMANT ADDRESS MARGARET SCHELLER ABOVE | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cor. Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>Diabetes Mellitus Hypertension</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>11-6-81</u> to <u>11-6-81</u> (that (I) (we) last saw the deceased alive on <u>11-6-81</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <u>Theresa P. Niznik</u> DEGREE | | | | 22c DATE SIGNED 11-25-81 | | 22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT) T. G. NIZNIK | | | | 22f ADDRESS 429 S. Chester St 21231 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b DATE 11/25/81 | | 23c NAME OF CEMETERY OR CREMATORY SECURITY PROCESS | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | |
| 24 FUNERAL DIRECTOR NAME J. G. CONNELLY | | | | 24b ADDRESS 300 MACE | | 25a DATE REC'D. BY REGISTRAR DEC 1 1981 | |
| 25b REGISTRAR'S SIGNATURE <u>James J. [Signature]</u> | | | | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 1 2 8 2 6 9

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Pearl Schlag | | 2a. DATE OF DEATH MONTH DAY YEAR November 5, 1981 | | 2b. HOUR M <input checked="" type="checkbox"/> | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 28, 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley Nursing & Convalescent | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4400 Arabia Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Phoebus | | 15. MOTHER'S MAIDEN NAME ? FIRST ? MIDDLE ? LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-32-0631 | | 17. INFORMANT Mrs June Weidner | | ADDRESS 2114 Taylor Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Sept- 11-2 , 19 81 , to 11-5 , 19 81 that (I) (we) last saw the deceased alive on 11-2 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Marion C. Kowalewski | | DEGREE KOWALEWSKI Marion Kowalewski M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-6-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Marion Kowalewski M.D. | | 8604 Harford Rd | | Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR NOV 6 1981 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Warren | | | |

UNITED STATES
NAVY
OFFICE



NOV 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 5-1 28270 | |
|--|--|---|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl R Schmidt | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 10 81 2b. HOUR 10:20A | |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3 3 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD. | |
| 10. CITY OR TOWN OF DEATH Balto. 21207 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Augsburg Lutheran Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VP. BG&E Light Co. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Schmidt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katharine Hilgartner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I | | 16b. SOCIAL SECURITY NO. 215-09-1082A | | 17. INFORMANT ADDRESS Mrs. Otto K. LeBron, Jr., Kansas City, KN | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Cardiovascular PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 11-1-81 to 11-10-81 , that (we) last saw the deceased alive on 11-10-81 , and that in (my) <input checked="" type="checkbox"/> own opinion death occurred on the date and hour and from the causes stated above. (If (I) <input type="checkbox"/> view the body after death. | | | | | |
| 22b. SIGNATURE K. NAIR | | DEGREE MD | | 22c. DATE SIGNED 11-10-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. NAIR | | 22e. ADDRESS 5010 York Road, BALTO. MD 21212 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/13/81 | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., Md. | | 24. FUNERAL DIRECTOR NAME (TYPE OR PRINT) ADDRESS Starkins F. H. 4905 York Rd. BALTO. MD 21212 | | | |
| 25. DATE REC'D. BY REGISTRAR NOV 13 1981 | | 26. REGISTRAR'S SIGNATURE James J. H. Nathan | | | |

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|--|--|--|--|------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) CATHERINE Mary SCHMIDT | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 18 81 | | 2b. HOUR 6:30 A | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 9/9/05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE - LUTON | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. | | 13b. COUNTY Balto. | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 9900 Forge Pk.Rd., PerryHall Md. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Fiedler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Wagner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS Margaret McLeary, 17 Haddington Rd. Lutherville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic CA of Bladder 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 11/21 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. Celar Parra | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Celar Parra | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/21/81 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Schimmunek Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 20 1981 | | 25b. REGISTRAR'S SIGNATURE James Santhorne | | | | | |
| 24. ADDRESS 3331 Brehms Lane, Balto., Md. 21213 | | | | | | | | | | | |

30

Handwritten text, possibly a date or name.

Handwritten text, possibly a signature or name.

Handwritten text, possibly a signature or name.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 7 2

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) RAYMOND M. SCHNEIDER | | 2a. DATE OF DEATH MONTH DAY YEAR November 4, 1981 | |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR 9 01 1892 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS | |
| 10 CITY OR TOWN OF DEATH Catonsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summitt Nursing Home | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | 12b. KIND OF BUSINESS OR INDUSTRY Retired Organist | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST late John J. Schneider | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Margaret | 13b. STREET ADDRESS 6011 Old Lawyers Hill Road | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO 269 32 5218 | 17 INFORMANT ADDRESS Raymond J. Schneider 6011 Old Lawyers Hill Rd 21227 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>and pneumonitis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/9 19 81 to 10/4 19 81, that (I) (we) lost the deceased above on 10/3 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE James E. Rowe M.D. | | 22c. DATE SIGNED 10/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. ROWE | | 22e. ADDRESS Summitt Nursing Home | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov 9, 1981 | |
| 23c. NAME OF CEMETERY OR CREMATORY St Mary's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cleveland Ohio | |
| 24 FUNERAL DIRECTOR NAME Harry H Witzke | | 25a. DATE REC'D BY REGISTRAR NOV 6 1981 | |
| 25b. REGISTRAR'S SIGNATURE James E. Rowe | | 25c. REGISTRAR'S SIGNATURE James E. Rowe | |

30

November 1, 1942

Mr. J. Edgar Hoover

Director

F.B.I.

Washington, D.C.

Dear Sir:

Enclosed for you are

three copies of

the report of

the committee

on the subject of

the activities of

the Japanese in the

United States and its possessions.

Very truly,
Yours,
J. Edgar Hoover



Enclosed 3/12

100-100000-100000

100-100000-100000

100-100000-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 7 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy C. Schueler | | | 2a DATE OF DEATH MONTH DAY YEAR 11 24 81 | | 2b HOUR 7:50 AM |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR 10 17 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | 7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10 CITY OR TOWN OF DEATH Catonsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Little Sisters of the Poor | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE Maryland | | 13b COUNTY | 13c CITY OR TOWN Baltimore | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS 4223 Euclid Ave. |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Thomas Ellard | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lambert | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b SOCIAL SECURITY NO. 220-12-8552 | | 17 INFORMANT ADDRESS Sr. Maureen 601 Maiden Choice Lane, Balto. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>Cerebral vascular Accident</i> 2397 DUE TO, OR AS A CONSEQUENCE OF (b). <i>History of brain damage - Epilepsy</i> DUE TO, OR AS A CONSEQUENCE OF (c). <i>History of Pituitary tumor removal</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>11-23-81</i> to <i>11-24-81</i> that (I) (we) last saw the deceased alive on <i>11-23-81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 27b. SIGNATURE <i>Stanley Ankudars</i> | | DEGREE M.D. | | 27c. DATE SIGNED 11-24-81 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY ANKUDARS | | 27e. ADDRESS 1101 Maiden Choice Ln. Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 11/27/81 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 23d. LOCATION CITY OR TOWN Baltimore | 23e. STATE Maryland |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | BALTO. MD. 21229 | | 25a. DATE REC'D. BY REGISTRAR NOV 25 1981 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

28274

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie C. Schwalenberg | | | 2a DATE OF DEATH MONTH DAY YEAR November 26, 1981 | | 2b HOUR 10 P M |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR December 13, 1893 | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD | |
| 10 CITY OR TOWN OF DEATH Towson | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1114 Stevenson Lane | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | 12b KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a STATE Maryland | | 13b COUNTY Baltimore | 13c CITY OR TOWN Towson | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS 1114 Stevenson Lane |
| 14 FATHER'S NAME FIRST MIDDLE LAST Frank Michel | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Baummer | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 212-50-4931 | | 17. INFORMANT ADDRESS Rev. Martin A. Schwalenberg 101 Church Lane | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute CVH 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUETO, OR AS A CONSEQUENCE OF Chronic HSCVD with DUETO, OR AS A CONSEQUENCE OF Multiple Myocardial (c) infarction | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 4/26/81 to 11/26/81 , that (I) (we) (we) saw the deceased alive on 11/26/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Charles F. O'Donnell | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 11/27/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. O'Donnell, M.D. | | 22e ADDRESS 7501 York Road Towson, Maryland 21204 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE Nov.30, 1981 | 23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery Baltimore, Maryland | | 23d LOCATION CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | ADDRESS 1050 York Road | | 25a DATE REC'D. BY REGISTRAR DEC 1 1981 | 25b REGISTRAR'S SIGNATURE Rome Jones |

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

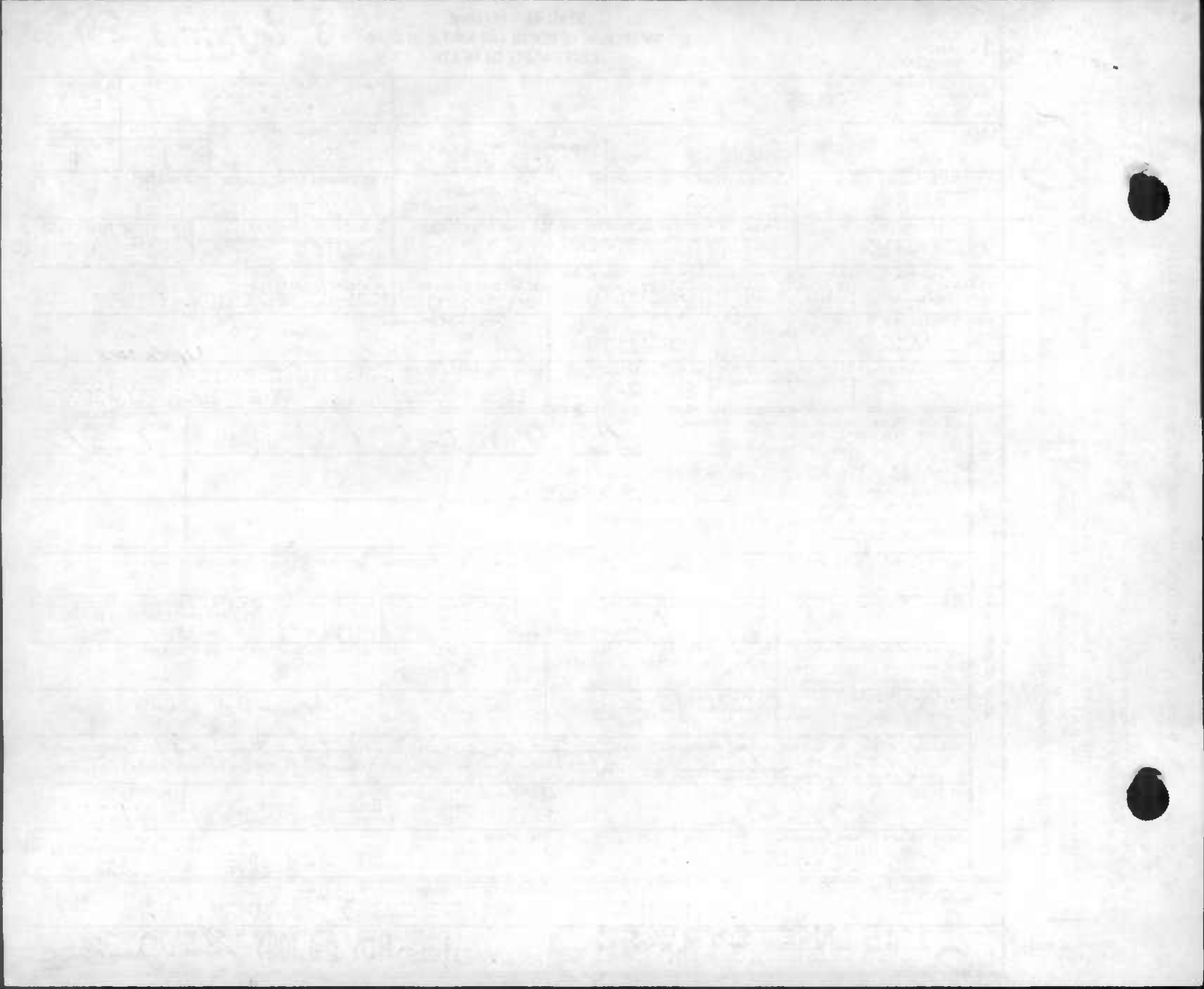
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 7 5

REG. NO.

| | | | | | | | | | |
|---|--------|---|-----------------|--|--------------------------------|---|-------------------|--|-------------------|
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR |
| LOUIS | | D. | | SCHWARTZ | NOV. | 17, | 1981 | | 9:55AM |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS |
| MALE | WHITE | | DEC. 3, 1898 | | 82 | | MONTHS | | DAYS |
| 9a BIRTHPLACE (STATE OR FOREIGN) | | 9b CITIZEN OF WHAT COUNTRY? | | 10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 11 BALTIMORE CITY OR COUNTY OF DEATH | | 12a USUAL OCCUPATION | |
| RUSSIA | | USA | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE C. COUNTY | | TAILOR | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12b KIND OF BUSINESS OR | | 13a STREET ADDRESS | | 14b KIND OF BUSINESS OR | |
| PIKESVILLE | | PIKESVILLE NURSING HOME | | INDUSTRY | | 3721 PIKESWOOD DR. (21133) | | LADIES CLOTHING | |
| 15 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 16a STATE | | 16b COUNTY | | 16c CITY OR TOWN | | 16d INSIDE CITY LIMITS? | | 16e STREET ADDRESS | |
| MARYLAND | | BALTIMORE | | RANDALLSTOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3721 PIKESWOOD DR. (21133) | |
| 17 FATHER'S NAME | | 18 MOTHER'S MAIDEN NAME | | 19 INFORMANT | | 20 ADDRESS | | 21 UNKNOWN | |
| ISAAC | | MINNIE | | MR. JOSEPH SCHWARTZ | | 11302 WOODLAND RD. | | LUTHERVILLE, MD 21093 | |
| 22a WAS DECEASED EVER IN U.S. ARMED FORCES? | | 22b SOCIAL SECURITY NO | | 22c | | 22d | | 22e | |
| (YES, NO OR UNKNOWN) | | 216-07-5896 | | | | | | | |
| 23 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>ASCD</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 24a DATE OF OPERATION | | 24b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 24c AUTOPSY? | | 24d IF YES, WERE FINDINGS USED | |
| | | <u>Pneumonia</u> | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 25a ACCIDENT WAS UNDERLYING <input type="checkbox"/> | | 25b TIME OF INJURY | | 25c HOW INJURY OCCURRED | | 25d | | 25e | |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | | | | | | |
| 26a INJURY OCCURRED | | 26b PLACE OF INJURY | | 26c LOCATION | | 26d | | 26e | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | |
| 27a I certify that (1) this hospital attended the deceased from 19 <u>82</u> to <u>11/17</u> 19 <u>81</u> , that (2) (we) last saw the deceased alive on <u>11/14</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 27b SIGNATURE | | DEGREE | | 27c | | 27d DATE SIGNED | | 27e | |
| <u>Morton J. Ellin</u> | | <u>M.D.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 11/17/81 | | | |
| 27d PHYSICIAN'S NAME (TYPE OR PRINT) | | 27e ADDRESS | | 27f | | 27g | | 27h | |
| MORTON J. ELLIN, M.D. | | 5310 OLD COURT RD. (21133) | | RANDALLSTOWN, MD | | 21133 | | | |
| 28a BURIAL, CREMATION, REMOVAL | | 28b DATE | | 28c NAME OF CEMETERY OR CREMATORY | | 28d LOCATION | | 28e | |
| (SPECIFY) | | NOV. 19, 1981 | | ANSHE EMUNAH (AITZ CHAIM) | | BALTIMORE, MD. | | | |
| 29a FUNERAL DIRECTOR | | 29b | | 29c DATE REC'D. BY REGISTRAR | | 29d REGISTRAR'S SIGNATURE | | 29e | |
| NAME | | ADDRESS | | NOV 20 1981 | | <u>James J. Mather</u> | | | |
| SOL LEVINSON & BROS | | 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 81 28276 | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Guy LeGrand Scott | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 26 81 | |
| 3 SEX Male 4 RACE White 5. DATE OF BIRTH DAY MONTH YEAR AUG. 19 1899 | | | | | | | | | | 2b. HOUR 245 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina 7b. CITIZEN OF WHAT COUNTRY? U. S. A. 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 82 | |
| 10 CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton, Balto. Co. | | | | | | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Supervisor 12b. KIND OF BUSINESS OR INDUSTRY Food | | | | | | | | | | | |
| 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Lutherville 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 1605 Bellona Ave 21093 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST James Day Scott 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen McLean | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN <input type="checkbox"/> IF YES, GIVE WAR OR DATES No 16b. SOCIAL SECURITY NO. 213 09 6969 17 INFORMANT ADDRESS Mrs. Phyllis C. Scott 1605 Bellona Ave | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4392 Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Due to, or as a consequence of, Atherosclerotic Cordes Vascular disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9 Nov 81 26 Nov 81 | | | | | | | | | | | |
| 22a. I certify that (I) (his) hospital attended the deceased from 9 Nov 81 to 26 Nov 81 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Walter T. Kees DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. KEES 22e. ADDRESS Monkton, MD 21111 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 28 NOV 81 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Towson, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR (NAME) J. E. Lovell ADDRESS 10 West Padonia Rd. 25a. DATE REC'D. BY REGISTRAR NOV 27 1981 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | | | | | | | | | |

BP

2007

Gray

82

White

White

Mar

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 2 8 2 7 7 | |
|---|--|---|--|---|--|--|--|---|-----------------------------------|--|--|
| FOR 1. STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) George Seidl | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 9, 1981 | | | 2b. HOUR 3:30A M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 28 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Carney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8805 Lakewood Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed Contractor | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Carney | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8805 Lakewood Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bart Carney | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Schott | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | | 17. INFORMANT Son: | | ADDRESS Raymond Seidl 8805 Lakewood Rd. 21234 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiomyopathy Arteriosclerotic Cardio Vase Disease</i> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <i>With Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Moderately severe Chronic Obstructive Lung Disease</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 8</i> , 19 <i>81</i> , to <i>Nov 9</i> , 19 <i>81</i> , that (I) (we) last observed the deceased alive on <i>Nov 8</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Frank T. Kasik, Jr.</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-9-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank T. Kasik, Jr., M.D. | | | | | | 22e. ADDRESS 9005 Harford Rd. Balto. MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11-12-81 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd. 21214 | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 9 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Van Hatten</i> | | | |

BP

3:30A

Carbonyl Chloride
a little Carbonyl Chloride

that is, the Chlorine
X

12 2 21

12 8 21

Chlorine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SALVADOR DAVID SELINA | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 12, 1981 | | 2b. HOUR P M 9:45 P M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 21, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER | | 12a. USUAL OCCUPATION (GIVE WORKING LIFE) CAB DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY CAB COMPANY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY VA 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SEBASTIAN SELINA | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANGELA BUTTA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII | | 16b. SOCIAL SECURITY NO. 219 10 1600 | | 17. INFORMANT ADDRESS Mrs. Marie A. Selina Same as # 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) BILATERAL NEPHROSCLEROSIS Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 4049 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS YEARS YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIVERTICULOSIS OF COLON; ANEMIA, UREMIA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 28, 1981 , to NOVEMBER 12, 1981 , that (I) (we) lost saw the deceased alive on NOVEMBER 12, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Vadhana Claud</i> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VADHANA CLAUD, M.D. | | | | 22c. DATE SIGNED 11/13/81 22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 16, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | ADDRESS Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR NOV 16 | |
| 25b. REGISTRAR'S SIGNATURE <i>James J. Heston</i> | | | | | |

EX 212 TO 1600

NOVEMBER 12, 1961

GALLAGHER DAVID BERRY NOVEMBER 12, 1961 212

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

NOVEMBER 12, 1961

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

WINTER JANUARY 21, 1961 TO

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 7 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY SHABEK SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-27-81 11-27-81 | | 2b. HOUR MIN. 5:17am 5:17am | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 8-13-93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Piano Tuner | | 12b. KIND OF BUSINESS OR INDUSTRY - |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS Valley Nursing Home | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anton Shabek | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Schmidt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 212-18-7386 | | 17. INFORMANT Anthony Shabek Jr. (son) | | ADDRESS Towson, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 4850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4860 | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-26 19 81 , to 11-27 19 81 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 11-27-81 19 81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Peter A. Holt MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-27-81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter A. Holt MD | | 22e. ADDRESS St Joseph's Hospital Balto MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/28/81 | | 23c. NAME OF CEMETERY OR CREMATORY Bohemian National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE James VanNathan | | |

MEDICAL CERTIFICATION

29

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-11-1914

10-11-1914

10-11-1914

10-11-1914

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|-----------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. | | | |
| BAPULAL G. SHAH | | 10 30 81 | | 10 30 | | 10 A.M. | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | Caucasian | 11/25/1901 | 80 | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| India | India | | Baltimore County, MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Randallstown | Baltimore County General Hospital | | Cashier-Ret. | | Cotton Indus. | | | | |
| 13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS | | | | | |
| Maryland | | Baltimore | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 14 Ritters Ridge Court | | | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Govinbial Shah | | Rookshmani | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | N/A | | Mina Patel, 8513 Portsmouth Dr., Laurel, Md | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | 45' | | | | | | | |
| IMMEDIATE CAUSE (a) Complete Heart Block | | | | | | | | | |
| 4100 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | 2 hrs | | | | | | | |
| (b) Acute Myocardial Infarction | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | Many years | | | | | | | |
| (c) Severe ASCVD. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Severe Mout, Anemia, Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 10/27/81 to 10/30/81, that (I) (we) lost saw the deceased alive on 10/30/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 10/30/81 | | | | | |
| Roberto P. Turnbull M.D. | | Baltimore County General Hospital. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | 10/31/81 | | Westview Mem. Park | | Catonsville, Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | | | |
| WOODLAWN MEMORIAL FH | | 11/13/81 | | James Santhorn | | | | | |
| 6111 Windsor Mill RD | | | | | | | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-374301)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [REDACTED] (C)

Re New York airtel to Bureau dated 1/11/61.
Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.
The LHM is being furnished to the Bureau for information.

Very truly yours,
[Signature]

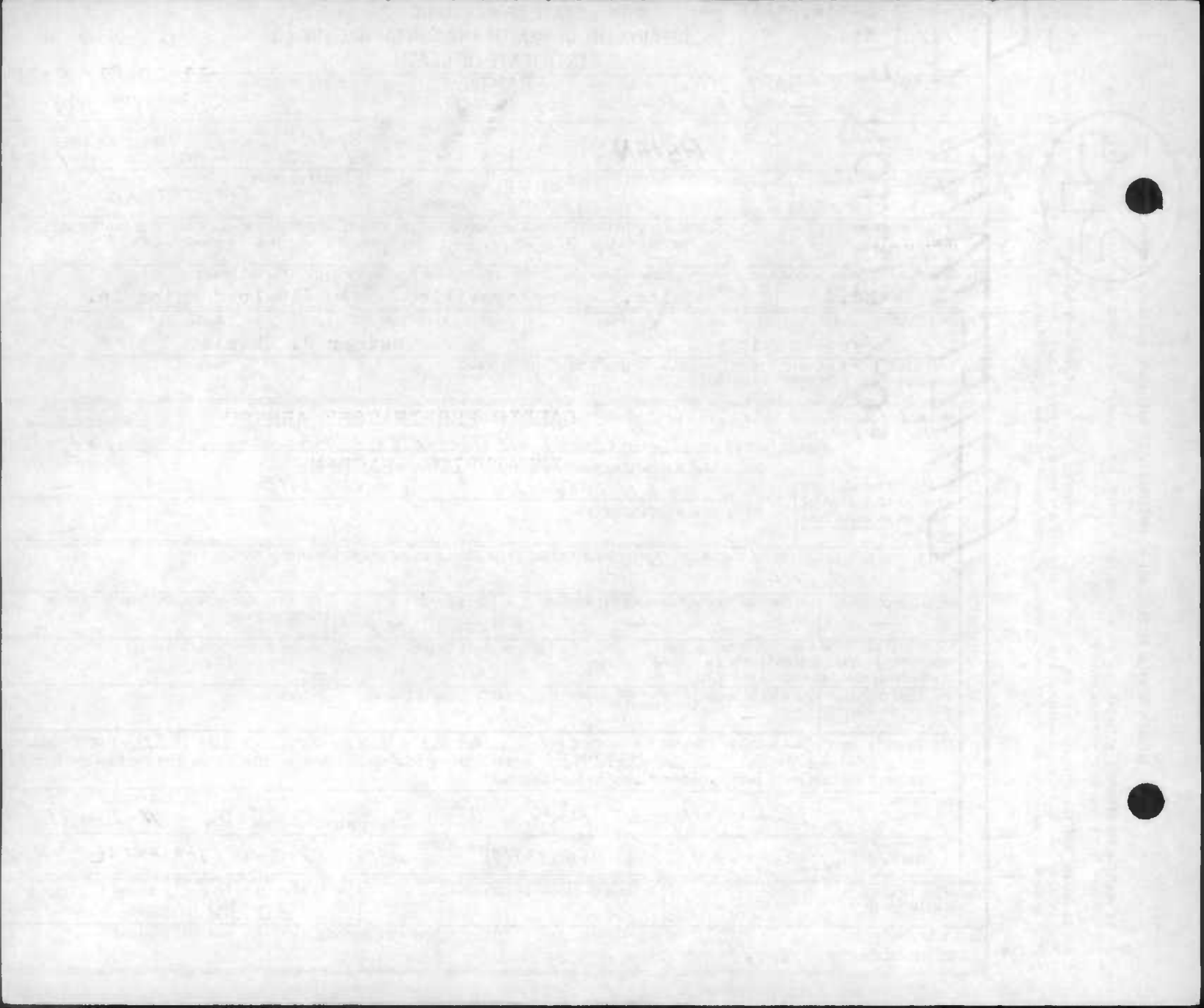
X

Enclosure
100-374301-100
100-100000-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | First <u>BABY BOY</u> Middle <u>SHAMIN</u> | | 2a. DATE OF DEATH <u>11-20-81</u> 2b. HOUR <u>9:30 PM</u> | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>ASIAN</u> | | 5. DATE OF BIRTH <u>11-20-81</u> 6. AGE (In years lost birthday) <u>8.03</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <u>SACTO.</u> | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH <u>BALTIMORE CO</u> | | 10. CITY OR TOWN OF DEATH <u>TOWSON</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Joseph's Hosp.</u> | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET AND NUMBER <u>319 Lord Byron Ln.</u> | |
| 13b. COUNTY <u>Balto.</u> | | 13c. CITY OR TOWN <u>Cockeysville</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <u>Fyed</u> Middle <u>Shamin</u> Last | | 15. MOTHER'S MAIDEN NAME First <u>Quaiser</u> Middle <u>J.</u> Last <u>Shamin</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> 7798 DUE TO, OR AS A CONSEQUENCE OF IMMATURITY, EXTREME (b) <u>IMMATURITY</u> & <u>EXTREME</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 27 min.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>NA.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-20-1981</u> to <u>11-20-1981</u> , that (I) (we) last saw the deceased alive on <u>11-20-1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Ronwan Wazant. MD.</u> DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>11-20-81</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>PORNSWAN</u> | | 22e. ADDRESS <u>SAINT JOSEPH HOSPITAL. 8120X</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 23d. LOCATION (City or Town) (County) (State) <u>NOV 25 1981</u> <u>James J. White</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Leonard L. Buckner</u> | | ADDRESS <u>St Joseph Hospital</u> | | 25a. REC'D BY REGISTRAR DATE | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |



BP

DHMH-16 30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 2 8 2 8 2 | |
|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | REG. NO. | |
| 1a. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| WILLIAM MONROE SHIPLEY | | | | NOV 16 81 | |
| 2b. HOUR | | | | 8 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| MALE | | W | | MAR 26 95 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 86 | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE COUNTY | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| CATONSVILLE | | 630 NORTH BEND RD | | FOREMAN | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | |
| BYO R.R. | | MD | | BALTO | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | |
| CATONSVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 630 NORTH BEND RD. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) | |
| EDWARD COLUMBUS SHIPLEY | | CATHERINE S. CHEESEMAN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 705-053592 | | MARY A. SHIPLEY | | 630 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | years | |
| 4140 | | ASHD | | years | |
| IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1976 to 11/19 81, that (I) (we) lost saw the deceased alive on 11/15 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| James Nolan | | MD | | 11/17/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| J J NOLAN | | 1 Melrose Hill Ave Balt Md 21209 | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 11/19/81 | | MEADOWRIDGE | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| WEBER FUNERAL HOME | | NOV 18 1981 | | James J. Nolan | |
| ADDRESS | | 25c. REGISTRAR'S SIGNATURE | | | |
| EDMONDSON AVE | | MD | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

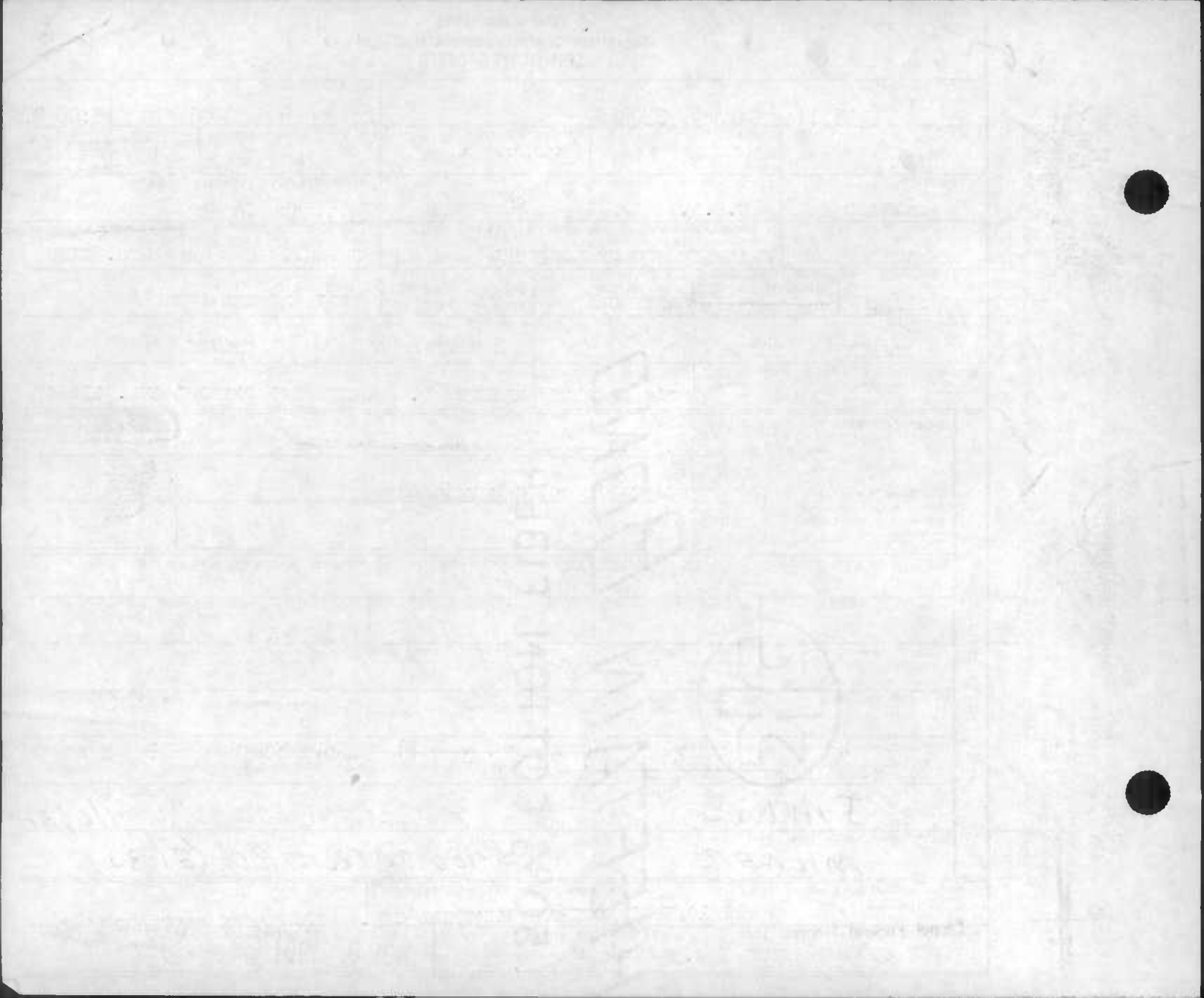
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| William Barney SHORES | | | | November 6, 1981 | | 6:00 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. | |
| MALE | | WHITE | | 10/ 21/ 1899 | | 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | | | Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ROSSVILLE | | FRANKLIN SQUARE HOSPITAL | | SUPERVISOR | | BALTO. CITY | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MARYLAND | | ----- | | BALTIMORE | | 13e. STREET ADDRESS 6827 FAIRDEL AVENUE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| BARNEY SHORES | | EMMA CURTIS | | YES | | 214 03 2226 | |
| 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia | | 17. INFORMANT ADDRESS | | 17. INFORMANT ADDRESS | |
| KATHRYN E. SHORES 6827 FAIRDEL AVE. 21234 | | 1539 | | DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic colon carcinoma | | DUE TO, OR AS A CONSEQUENCE OF (c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 4, 1981, to November 6, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. | | 22b. SIGNATURE S. Milner | | 22c. DATE SIGNED 11/6/81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MILNER | |
| 22e. ADDRESS 5400 Old Court Rd (21133) | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11/10/1981 | | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL CEM. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE | | 23f. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE | | 23g. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE | |
| BALTIMORE MARYLAND | | NOV 9 1981 | | Frances San Martin | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 8 4

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|--|----------------------|--|---|---|---|--------------------------------|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) | | FIRST ANNA | MIDDLE Catherines | LAST IBISKI | 2a. DATE OF DEATH MONTH DAY YEAR 11-27-81 | | 2b. HOUR 10:00am | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 1 26 17 | | 6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | |
| 10 CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY At Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3001 A Dunmurry Road 21222 | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Howard Clifton Wiley | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cunigunda Zorn | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-1070 | | 17. INFORMANT ADDRESS Margaret Wiley 3904 Foster Avenue 21224 | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RECURRENT BILE DUCT CARCINOMA WITH</u> <u>GENERALIZED ABDOMINAL CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10-31</u> , 19 <u>81</u> , to <u>11-27-</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11-27</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>A. Andrew Accoce, M.D.</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/28/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ANDREW ACCOCE, M.D. | | | | | | 22e. ADDRESS 7620 YORK ROAD TOWSON MD 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-1-81 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Co. Md. | | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS C.S. Zeiler & Son Inc. 6224 Eastern Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 30 1981 | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 8 5

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PHILIP SIDLE <i>SIDLE PHILLIP</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-12-81 | | 2b. HOUR 5:55 ^A | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 1 20 05 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT | |
| 12b. KIND OF BUSINESS OR INDUSTRY RETAIL | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 7 SLADE AVE., APT. 111 #21208 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACOB SIDLE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH LEVINSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-32-6440 | | 17. INFORMANT MRS. ISABELL SIDLE 7 SLADE AVE. APT. 111 BALTO., MD 21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest 2^o to</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>massive acute myocardial</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>infarction.</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-11-1981 to 11-12-1981, that (I) (we) last saw the deceased alive on 11-12-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R.M. Shah, M.D. | | | | DEGREE | | 22c. DATE SIGNED 11-12-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH, M.D. | | | | 22e. ADDRESS B.C.G.H. Old Court Road, RANDALLSTOWN, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE NOV. 13, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | 23d. LOCATION BALTIMORE COUNTY MARYLAND | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 16 1981 | | 25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i> | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

Items #18a-22a Film G563 1/7/82 re STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|---------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Carol | | | MIDDLE Ann | | | LAST Sinibaldi | | | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR M | | | | | |
| 3 SEX female | | | 4 RACE white | | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1952 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 28 YRS. | | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD 11 30 81 | | | 2d. HOUR M | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 Stevenson Lane | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY Catholic High | | | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Towson | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 1000 Stevenson Lane | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar G. Sinibaldi | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary H. Dogo | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-62-0073 | | | 17. INFORMANT Oscar G. Sinibaldi | | | ADDRESS Same as #13. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amitriptyline intoxication</u> 9503 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 11/30/1981 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/ingested | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | 21i. LOCATION STREET 1000 Stevenson Lane | | | CITY OR TOWN Towson | | | COUNTY Balto. Co. | | | STATE Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | TITLE (SPECIFY) Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 12/1/81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Dec. 5, 1981 | | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | | ADDRESS 1050 York Road Towson, Md. 21204 | | | 25a. DATE REC'D. BY REGISTRAR DEC 4 1981 | | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nithen | | | | | | | | | | | |

100

Dec. 24, 1931

U.S.A.

New Jersey

High School, New Jersey

1931-1932

Town

High School

High School

1931

1932

1933

1934

1935

1936

1937

1938

High School

Dec. 24, 1931
New Jersey
High School
1931-1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 8 7

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CECELIA D. SMINK | | | 2a. DATE OF DEATH November 15, 1981 | | | 2b. HOUR 8:17a M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH May 19 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN) Penna. | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 12. CITY OR TOWN OF DEATH Rossville 21237 | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator | | 15. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Essex 21221 | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1617 Dartford Rd. Apt A | |
| 14. FATHER'S NAME FIRST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST Josephine | | 16. ADDRESS 2130 Redthorn Rd. | | 17. INFORMANT Josephine Smyth, Daughter Balto., Md. 21220 | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 161 09 6768 | | 19. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock (clinical)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral Lower Lobe Acute Bronchopneumonia,</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Several Small Pulmonary Emboli</u> | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>4850</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 15, 19 81</u> , to <u>November 15, 19 81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 15, 19 81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Myo Thant</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-16-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myo Thant | | | | 22e. ADDRESS 9101 Franklin Square Drive 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 11/18/81 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | | 23d. LOCATION Baltimore Co., Md. | | | |
| 24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 17 1981 | | 25b. REGISTRAR'S SIGNATURE <i>James Dan Thant</i> | | | |



15/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed without signature after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and report filed.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 1 2 8 2 8 8 | |
|---|--|---|---|---|---|--|---|--|---|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) CAROLINE K SMITH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 5, 1981 | | 2b. HOUR 10:30P | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 23 E. Chesapeake Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Plageman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Spangler | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-9536 | | 17. INFORMANT ADDRESS Mr. Bernard M. Smith 910 Locustvale Road' | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis and stroke 4340 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT 15, 19 81 to NOV 5, 19 81 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOV 5, 19 81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> well (died) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A.H. Ghiladi | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 11-6-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.H. GHILADI | | | | | 22e. ADDRESS 7620-YORK ROAD TOWSON MD 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 11/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Long Green | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Hydes Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Road | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 9 1981 Frances Santhorne | | | | | | |

MEDICAL CERTIFICATION

NOVEMBER 2, 1957 - 10:15 PM

ENTER

CATHOLIC

BALTIMORE COUNTY

SANCT JOSEPH HOSPITAL

TOWSON

X

OCT 15 1957 NOV 2 1957 NOV 2 1957 NOV 2 1957

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDNA May SMITHSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 25 81 | | 2b. HOUR 7:30 A.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 05 29 1895 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | 7a. BIRTHPLACE (COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE ROSSVILLE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Homemaking | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Overlea | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Dinsmore | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Barwick | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-24-7566 | | 17. INFORMANT ADDRESS Francis S. Soistman, Jr., 20 Medici Ct. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many yrs | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus, genitourinary tract infection, Neutrophilic | | | | | | |
| 19a. DATE OF OPERATION X | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> ENROUTE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6-3 19 81 to 11-25-81 19 81 , that (we) last saw the deceased alive on 11-25-81 19 81 , and that in (my) mal. opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE John C. Hyle | | DEGREE mal. | | 22c. DATE SIGNED 11-25-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Hyle, M.D. | | 22e. ADDRESS 7527 Belair Road BALTO 21236 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lassahn Funeral Home 7401 Belair Road | | 25a. DATE REC'D. BY REGISTRAR NOV 30 1981 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VRA 15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28290

| | | | | | | | |
|---|---|--|---|---|-----------------------|---|--|
| 1. FOR STATE REGISTRAR | | 20. DATE KNOWN OF DEATH | | 21. DATE OF DEATH | | 22. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 20. DATE KNOWN OF DEATH | | 21. DATE OF DEATH | | 22. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | MONTH DAY YEAR | | M P | |
| ROSA E. LLEN SMITH | | 11 25 81 | | 11 25 81 | | 7:30 P | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 23. DATE PRONOUNCED DEAD | |
| female | white | MONTH DAY YEAR | LAST BIRTHDAY YRS. | MONTHS DAYS HOURS MIN | MONTHS DAYS HOURS MIN | MONTH DAY YEAR | |
| | | July 29, 1900 | 81 | | | 11 25 81 | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | USA | | | Baltimore County MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | Inglenook Nursing Home | | | Homemaker | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| Maryland | Howard | Ellicott City | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 9810 Gwynn Park Dr. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Thomas A. Hood | | Edith Mullineaux | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 216-10-9651 A | | Ellen M. Breeden | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an | | | | | | | |
| death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE | | SIGNED | |
| Ann M. Dixon, M.D. | | Assistant | | 11-26-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | |
| | | 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Nov. 28, 1981 | | Loudon Park | | Baltimore City, Maryland | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | 6500 York Rd. | | | | DEC 2 1981 | |

July 2, 1901

Carrying

Chromatite

Carrying

Carrying

July 2, 1901

Carrying

Carrying

July 2, 1901

Carrying

July 2, 1901

Carrying

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

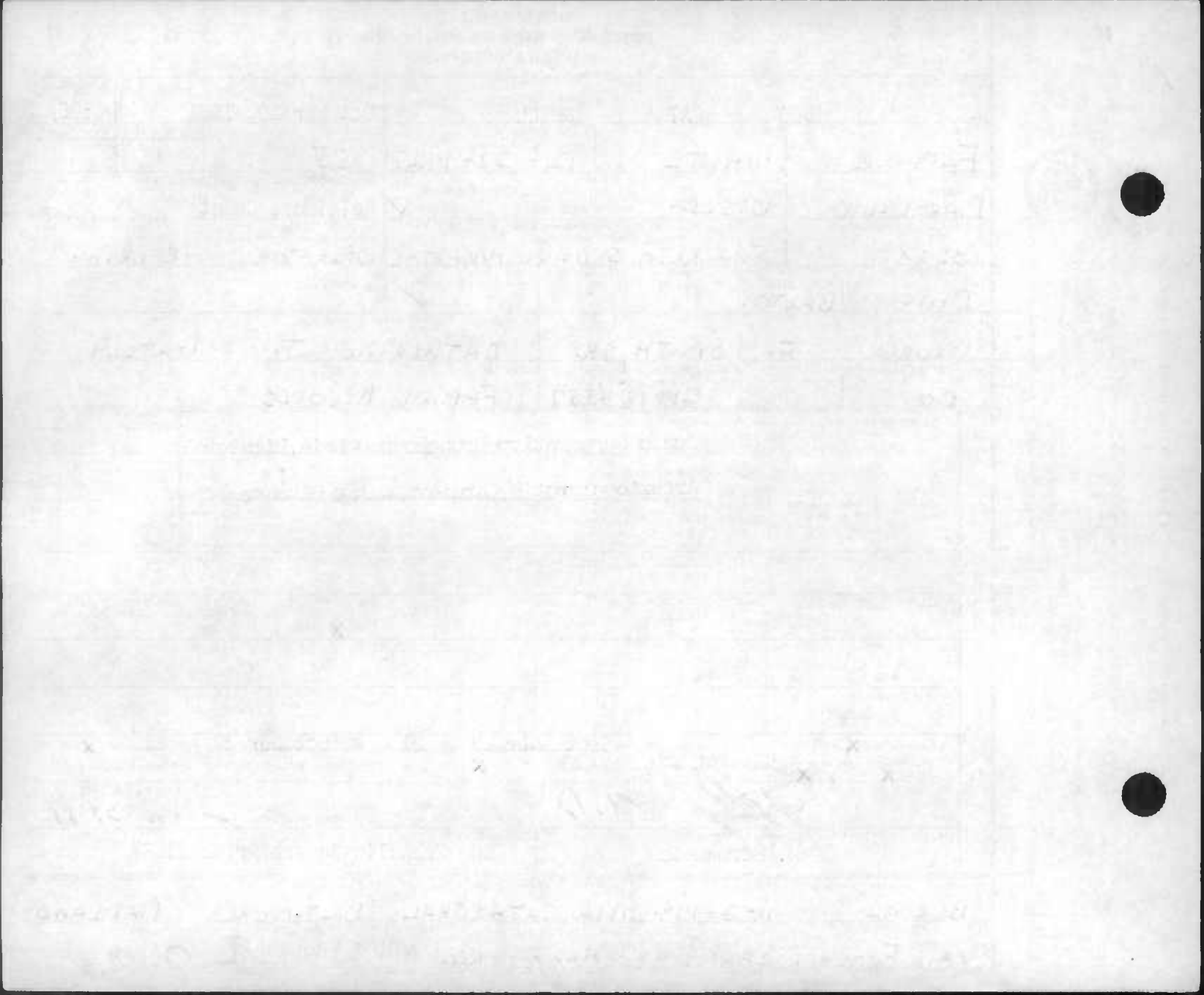
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 9 1

REG. NO.

| | | | | | | | |
|--|--|---|---|---|---------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE PAT LAST SNELL | | | 2a. DATE OF DEATH MONTH DAY YEAR October 29, 1981 | | 2b. HOUR 6:05p M | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 - 23 - 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | |
| 7a. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Essex | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Banking | |
| 13a. STATE MO. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George F. Smith Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine J. Gately | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 219 18 4557 | |
| 17. INFORMANT FAMILY RECORDS | | 17. ADDRESS | | 17. ADDRESS | | 17. ADDRESS | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Suppurative Bronchopneumonia, Bilateral 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from September 23, 19 81, to October 29, 19 81, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 29, 19 81, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE H. Hernandez | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10-29-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Hernandez | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11-2-1981 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHOLICAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL | | ADDRESS 8800 HAAFORD RD. | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1981 | | 25b. REGISTRAR'S SIGNATURE James J. Smith | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOIS STEWART SNELLING | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 18 81 | | 2b. HOUR 11-47A M |
| 3. SEX Female | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR 2 12 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 77 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY ---- |
| 13a. STATE Maryland | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Sparks | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Roland Tubbs | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabel NMN Shipley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-6222 | | 17. INFORMANT ADDRESS Sparks, Maryland 21152 Elaine Foster 16505 Yeoho Road | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) 2° to acute MI, vent. arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASCD | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-17-1981 to 11-18-1981 that (I) (we) lost saw the deceased alive on 11-18-1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE R.M. Shah. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 11-18-81. |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH. | | 22e. ADDRESS OLD CRT RD. 11647 RD. | |

| | | | |
|--|--------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 11/21/1981 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS J. E. Lowell Lemmon 10 W. Padonia Rd. | | 25a. DATE REC'D BY REGISTRAR NOV 20 1981 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Jan Nathan | |

BP

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLI'S SNYDER | | | | | | | | | | 2a. DATE OF DEATH MONTH 11 / DAY 26 / YEAR 81 | | 2b. HOUR 2:00 M. | | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH OCT. 22, 1917 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 | | | IF UNDER 1 YEAR MONTHS 0 / DAYS 0 / HOURS 0 / MIN. 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION BALTIMORE COUNTY GEN. HOSP. | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN WORKING LIFE) MERCHANT | | | 12b. KIND OF BUSINESS OR INDUSTRY RETAIL | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTIMORE | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 2835 MARNAT RD., APT. B | |
| 14. FATHER'S NAME FIRST NATHAN MIDDLE I. LAST SNYDER | | | | | | 15. MOTHER'S MAIDEN NAME FIRST LILLIAN MIDDLE PRUCCELL | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> UNKNOWN <input type="checkbox"/> NO <input type="checkbox"/> WWIT-ARMY | | | 16b. SOCIAL SECURITY NO. 213-03-8310 | | | 17. INFORMANT MRS. SYLVIA SNYDER | | | ADDRESS 2835 MARNAT RD., APT. B | | | # 21209 | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 10 days | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26 , 19 81 , to 11/26 , 19 81 , that (I) (we) last saw the deceased alive on 11/26 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Roberto L. Turnbull | | | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/26/81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roberto L. Turnbull | | | | | | | | 22e. ADDRESS Balto County Gen Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE NOV. 27, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | | | 25b. REGISTRAR'S SIGNATURE James Van Natten | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR AND PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

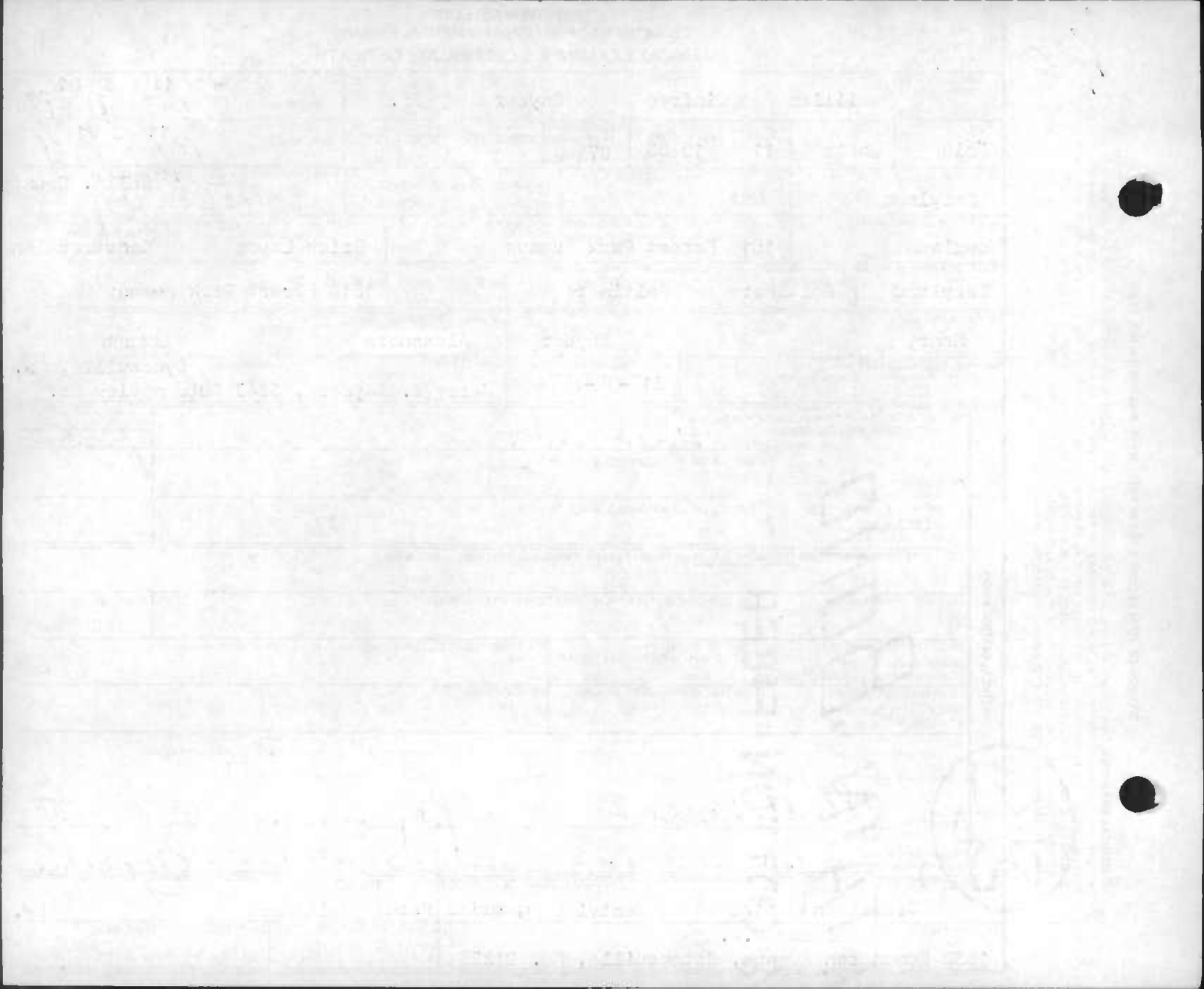
BP_____

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|------------------|---|---|--|----------------------------------|---|--|
| FOR 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 2 8 2 9 4 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) William Winfred Snyder Sr. | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED 11 3 1981 8 PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 15 83 | 6. AGE (IN YEARS) LAST BIRTHDAY 97 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN | 9. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 3 1981 9 PM | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 11. CITIZEN OF WHAT COUNTRY? USA | | 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 14. CITY OR TOWN OF DEATH Woodlawn | | 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1518 Forest Park Avenue | | | | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Layer | |
| 17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18a. STATE Maryland | | 18b. CITY OR TOWN Baltimore | | 18c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 18d. STREET ADDRESS 1518 Forest Park Avenue | |
| 19. FATHER'S NAME FIRST MIDDLE LAST Henry Snyder | | | | 20. MOTHER'S MAIDEN NAME MIDDLE LAST Alexia Ebaugh | | | |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 21b. SOCIAL SECURITY NO. 317-07-5574 | | 21c. INFORMANT ADDRESS Sykesville, Md. Harry E. Snyder, 6849 Autumn View Dr. | | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4393 IMMEDIATE CAUSE (a) A.S.C., V.D. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 HRS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 23a. DATE OF OPERATION | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 23c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 24a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 25a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 25c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 26. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| 27. ACTUAL SIGNATURE William E. P. Williams II | | 27b. TITLE (SPECIFY) M.D. Deputy | | 27c. MEDICAL EXAMINER | | 27d. DATE SIGNED 11/4/81 | |
| 28. EXAMINER'S NAME (TYPE OR PRINT) E. P. Williams II | | 28b. ADDRESS 5550 BALTONA TRL Pk 4228 | | | | | |
| 29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 29b. DATE 11/6/81 | | 29c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park | | 29d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 30. FUNERAL DIRECTOR NAME ADDRESS Witzke P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | 30b. DATE REC'D. BY REGISTRAR NOV 6 1981 | | | |
| | | | | 30c. REGISTRAR'S SIGNATURE James J. Martin | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

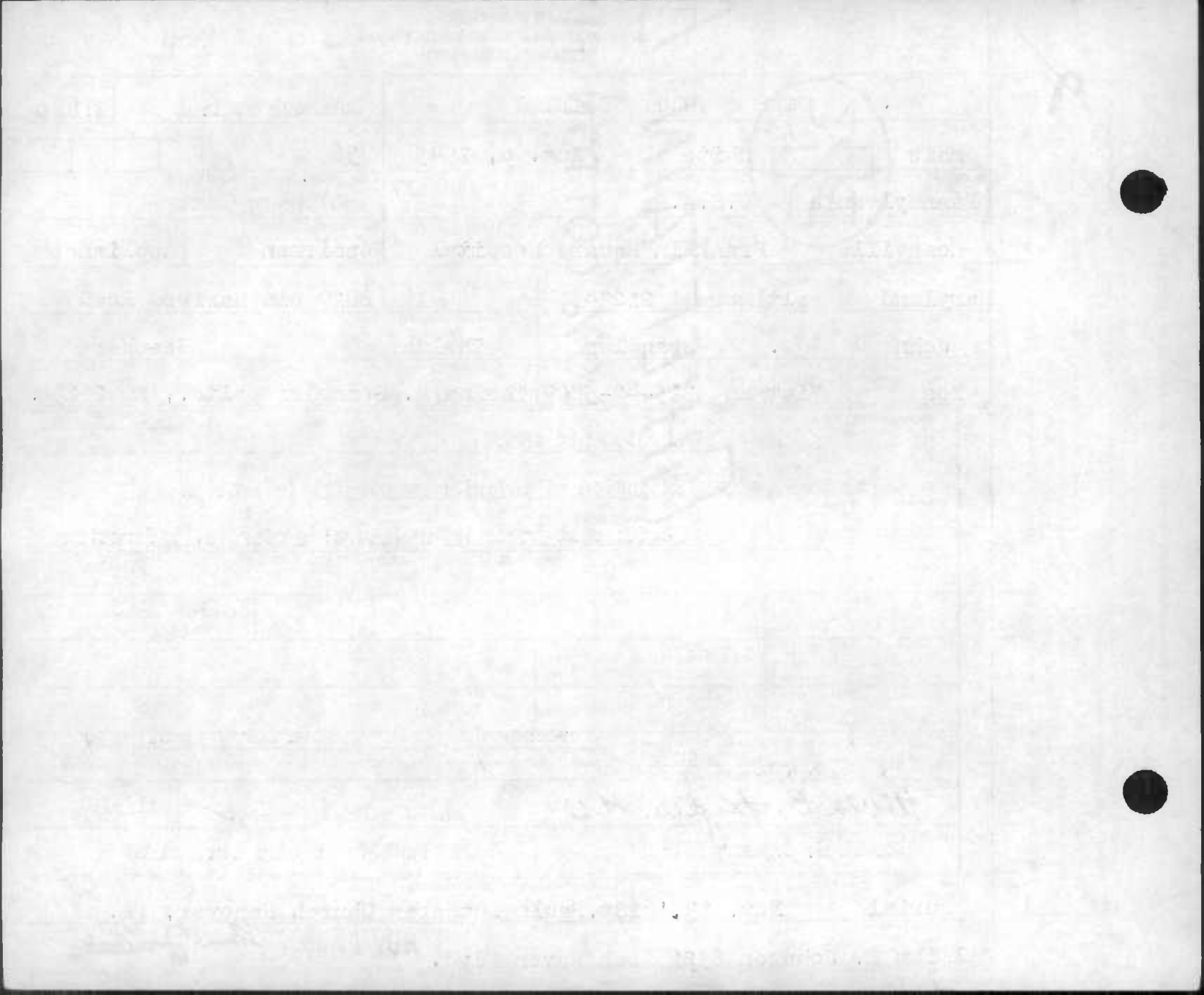
28295

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) James Allen SPANGLER | | | 2a. DATE OF DEATH MONTH DAY YEAR November 9, 1981 | | 2b. HOUR 2:10 PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1945 | 6. AGE (IN YEARS-LAST BIRTHDAY) 36 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| CITY OR TOWN OF DEATH Rossville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman | 12b. KIND OF BUSINESS OR INDUSTRY Appliance | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN 21234 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 8827 Old Harford Road |
| 14. FATHER'S NAME FIRST MIDDLE LAST John W. Spangler | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Beecher | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam | | 17. INFORMANT ADDRESS Thelma B. Spangler Balto., MD 21234 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic shock 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Extension of inferior myocardial infarction (c) Status post acute inferolateral myocardial infarction | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 8, 1981 to November 9, 1981 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on November 9, 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Steven B. Snyder, M.D. DEGREE | | | | 22c. DATE SIGNED 11/9/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven B. Snyder MD | | | | 22e. ADDRESS 9000 Franklin; Square Dr., 21237 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 13, '81 | | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Church Hanover, PA. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR NOV 12 1981 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd. | | | | | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 2 9 6

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frank E. STANG | | | 2a. DATE OF DEATH MONTH DAY YEAR November 17, 1981 | | 2b. HOUR 11:15am M | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH May 10 DAY 1907 ^{AR} | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Theatre | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME George | | 15. MOTHER'S MAIDEN NAME Sally | | 13e. STREET ADDRESS 3561 Elmley Ave. 21213 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-0844 | | 17. INFORMANT ADDRESS Mary C. Stang Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic and Hypertensive Cardio-</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>vascular Disease with old and recent</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarctions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 5</u> , 19 <u>81</u> , to <u>November 17</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (e) last saw the deceased alive on <u>November 17</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Steven B. Snyder, M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 11/17/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven B. Snyder, M.D. | | | | 22e. ADDRESS 9000 Franklin Square Dr., Balto., MD 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/20/81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 23d. LOCATION Baltimore, Md. COUNTY STATE | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms La.-Balto., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 20 1981 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>James J. Matthews</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/24/41

10/24/41

10/24/41

10/24/41

10/24/41

10/24/41

10/24/41

10/24/41

10/24/41

But...
of Britain

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH-16 50M7/77
(VR A 15 (4))TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove stubs on pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCILLE STEINS | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 3 81 | | | 2b. HOUR MIN. 6:15 AM | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 10 14 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. 67 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10 CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Catonsville | | | | | | | | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 817 Southridge Road | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George Schlau | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Marterer | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 134-03-4128 | | 17 INFORMANT ADDRESS Mr. Joseph E. Steins Same as # 13 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 3829 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic renal disease, Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ; | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months years - | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/15 , 19 71 , to 11/3 , 19 81 , that (I) (we) last saw the deceased alive on 10/31 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Cliff Ratliff Jr. | | | | | DEGREE M.D. | | | 22c. DATE SIGNED 11/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cliff Ratliff Jr. M.D. | | | | | 22e. ADDRESS 5772 Westview Mall, Baltimore, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE <input checked="" type="checkbox"/> | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Witzke P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 6 1981 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) VIRGINIA A. STERLING | | | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 19 81 | | | 2b. HOUR 10:00P | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 15, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPHS Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 617 N. Rose Street 21205 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arlin Moore | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Louise UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-05-8861 | | 17. INFORMANT ADDRESS Raymond Sterling Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Severe cirrhosis</u> (c) <u>Due to, or as a consequence of</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>1 year</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Sepsis, Septic shock.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Graci V. Patricia</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 11/19/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GRACI V. PATRICIA | | | | 22e. ADDRESS ST. Joseph Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/23/81 | | 23c. NAME OF CEMETERY OR CREMATORY Sunny Ridge Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield, Md. | | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane - Baltimore, Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 24 1981 | | 25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u> | | | |

NOV 10 1954

RECEIVED

ATLANTA

RECEIVED

NOV 10 1954

RECEIVED

NOV 10 1954

RECEIVED

ATLANTA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 2 8 2 9 9 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie E Stevens | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 21 81 | | | 2b. HOUR 5:15A ^M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 04 06 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Overlea | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15 Virginia Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaking | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Overlea | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John McNichlas | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gillen | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-7585 | | 17. INFORMANT ADDRESS Patricia Jost 15 Virginia Avenue | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe COPD</u> <u>4960</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/17/1981</u> to <u>11/18/1981</u> , that (I) (we) last saw the deceased alive on <u>11/18/1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Donald Sherbourne M.D.</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 11/23/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Sherbourne, M.D. | | | | | 22e. ADDRESS 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 25 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(V.R. 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 2 8 3 0 0 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Ruth Estelle Stevens | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 30 81 | | | 2b. HOUR 11 55 A M | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 26 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12530 Eastern Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaking | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Chase | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Haise | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Schillman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-44-6381 | | 17. INFORMANT ADDRESS Sarah F. Paul 10406 Vincent Farm Lane | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4029</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN DEATH</u> <u>11 YEARS</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>DIABETES MELLITUS</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>JAN. 23</u> , 19 <u>80</u> , to <u>Nov. 30</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>JULY 13</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Joseph Micelli, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>12/1/81</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Micelli, M. D. | | | | 22e. ADDRESS 108 S. Taylor Avenue | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/3/81 | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | | | ADDRESS 7401 Belair Road | | 25a. REG'D. BY REGISTRAR <u>DEC 7 1981</u> | | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 28301 | | | |
|---|--|-----------------|--|--|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wayne Richard Stevens, Jr. | | | | | | | | | | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 11 21 81 | | HOUR M a | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11/5/62 | | 6. AGE (IN YEARS) LAST BIRTHDAY 19 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 11 21 81 | | 2d. HOUR M a | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Arbutus | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southwestern Blvd. s. of Francis Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1233 Brewster St. 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wayne R. Stevens, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gail Rehmeier | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 220-74-2890 | | 17. INFORMANT ADDRESS Gail R. Quinn 1233 Brewster St | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 8151 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chest Compression</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:15x 11 21 81 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in auto/fixed object impact | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE Arbutus Balto. Md. Southwestern Blvd s. of Francis Ave. | | | | | |
| 22a. I certify that I took charge of the remains described above, and on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | | | DATE SIGNED 11/21/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Ambrose, Inc. 1328 Sulphur Spring Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 23 1981 | | 25b. REGISTRAR'S SIGNATURE James Van Natten | | | | | |



LETTER BOARD

NO. 9 COLUMN TIER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2631 BP
DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 0 2

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry STONER | | 2a. DATE OF DEATH MONTH DAY YEAR November 8, 1981 | |
| 3. SEX Male | | 2b. HOUR 1130AM | |
| 4. RACE white | | 6. AGE (IN YEARS, LAST BIRTHDAY) 90 YRS. | |
| 5. DATE OF BIRTH MONTH DAY YEAR 6-29-1891 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE STATE OF FOREIGN COUNTRY Frederick Co. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Charles Stoner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret A. Young | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-09-9271 | |
| 17. INFORMANT ADDRESS Mrs. Mary E. McFarland-4213 Raspe Ave. 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Progressive inanition (c) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 27 , 19 81 , to Nov. 8 , 19 81 , that (I) (we) last saw the deceased alive on November 8 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE S. Miller | | DEGREE M.D. | |
| 22c. DATE SIGNED 11/9/81 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. MILLER | | 22e. ADDRESS 5400 Old Court Rd Randallstown 21133 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-11-81 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. -21206 | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd. -21206 | | 25. DATE REC'D. BY REGISTRAR NOV 9 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|--|---|---|---|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | 2b. HOUR | | |
| LIS STRAUSE | | | November 5, 1981 6:04p M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS |
| F | W | 6 20 40 | 41 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| DENMARK | USA | | Baltimore County MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| ESSEX | FRANKLIN SQ. HOSPITAL | | HSE | | |
| 13a. STATE | | | 13b. CITY OR TOWN | 13c. STREET ADDRESS | |
| MD | | | BALTO | EAST POINT | 410 SCARSDALE RD |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | |
| MORTON LANGE LUND | | | AGNES | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| NO | | | 218-82-0911 | | |
| 17. INFORMANT ADDRESS | | | 17. INFORMANT ADDRESS | | |
| NO | | | ALLEN STRAUSE HUSBAND ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 5789 Gastrointestinal Hemorrhage complicating Cirrhosis of Liver | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 19 19 81 to November 5 19 81, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 5 19 81, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | |
| Irving Gottfried MD | | | | 11/5/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Irving Gottfried | | | | 9000 Franklin Square Drive 21237 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 11/9/81 | HOLLY HILL | BALTO MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |
| J.G. CONNELLY 300 MAIZE AVE | | | NOV 10 1981 Frances Jan Narten | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28304

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | |
|---|---------|------------------|---|----------------|------------------|---|--|--|--|--|--|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2b. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2c. HOUR | | |
| Myrtle | | | Streett | | | 11 | | | 30 | | | 1981 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | |
| F | M | 1 1 95 | 86 YRS. | | | 11 | | | 30 | | | 1981 | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 11. CITIZEN OF WHAT COUNTRY | | | 12. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Maryland | | | USA | | | BALTI-COUNTY MD | | | | | | | | |
| 13. CITY OR TOWN OF DEATH | | | 14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 16. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Catonsville | | | Blond Bernard Bldg - Longview | | | House work with owner | | | | | | | | |
| 17a. USUAL RESIDENCE (IF IN BALTIMORE CITY OR OTHER INSTITUTION, GIVE STREET ADDRESS) | | | 17b. CITY OR TOWN | | | 17c. INSIDE CITY LIMITS? | | | 17d. STREET ADDRESS | | | | | |
| md. | | | HART. | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 18. FATHER'S NAME | | | 19. MOTHER'S MAIDEN NAME | | | 20. SOCIAL SECURITY NO. | | | 21. INFORMANT | | | 22. ADDRESS | | |
| Richard Mechem | | | Ella Bull | | | 3442 | | | Russell | | | 1-838-1297 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | 1-838-1297 | | |
| No | | | 219-54-3442 | | | Russell | | | Streett-Belair Md. | | | 1-838-1297 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4292 | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | |
| | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | MEDICAL EXAMINER | | | DATE SIGNED | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | |
| F-P-Williamson | | | 5550 BALT. NAT'L PK 21278 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | |
| Removal | | | 12/9/81 | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR | | | NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Anatomy Board | | | Balto., Md. | | | | | | DEC 11 1981 | | | Frances Jan Nathan | | |

MEDICAL CERTIFICATION

1100

1100

1100

1100

1100



1100

1100

1100

1100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 28305 | | | |
|--|--|-------------------------|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Zachary Bartholmew Strutt | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR November 12 1981 | | 2b. HOUR AM PM 4:30 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1981 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 2 | | IF UNDER 1 YR MONTHS DAYS HOURS MIN. 2 | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR November 12 1981 | | 2d. HOUR AM PM 4:30 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC | | | | 12a. USUAL OCCUPATION (TITLE OF WORK FOR MOST OF WORKING LIFE) ----- | | | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Phoenix | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8 Stag Court | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Kimberly B. Strutt | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gloria J. Hurst | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT Kimberly B. Strutt | | | | ADDRESS Phoenix, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death 7468 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Enlarged Heart DUE TO, OR AS A CONSEQUENCE OF (c) ----- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Hrs | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I ----- | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 11/16/81 | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell | | | | ADDRESS 7501 York Road, Towson, Md. 212 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto. Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Lemmon Mitchell-Wiedefeld, | | | | ADDRESS 10 W. Padonia | | | | 25a. DATE REC'D. BY REGISTRAR NOV 16 1981 | | | | 25b. REGISTRAR'S SIGNATURE James Van Natten | |

1944

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81
(VRA 15, 4)

6

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 2 8 3 0 6

| | | | | | |
|---|---|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Abraham Sudhalter | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 2 81 | | 2b. HOUR 5:25 PM |
| 3 SEX MALE | 4 RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 04 09 1905 | | 6. AGE (IN YEARS/LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (CITY OR FOREIGN COUNTRY) MASS. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PERSONNEL SUPVSR. | | 12b. KIND OF BUSINESS OR INDUSTRY CAB CO. |
| 13a. STATE MD | | 13b. CITY OR TOWN BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID SOODHALTER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CIRCLE APT XXXX 202 UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 042-07-7471 | | 17. INFORMANT MRS. ROSE SUDHALTER 7930 DUNHILL VILLAGE CIR., APT. 202 #21207 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable cardiac arrest. 429.2 DUE TO, OR AS A CONSEQUENCE OF, ASCUT Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a PUD; CODD, CHF, S/P CA stenosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10-23-81 to 11-2-81 that (1) (we) last saw the deceased alive on 10-23-81 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert J. AD | | DEGREE | | 22c. DATE SIGNED 11-2-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PEREZ OROZCO, M.D. | | 22e. ADDRESS 6000 REISTERSTOWN RD. 21207 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11-4-81 | 23c. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | 25a. DATE REC'D. BY REGISTRAR NOV 10 1981 | | |
| | | | 25b. REGISTRAR'S SIGNATURE James Van Nuthen | | |

MEDICAL CERTIFICATION

BP

11-5-81
11-5-81
11-5-81

11-5-81
11-5-81
11-5-81

11-5-81
11-5-81
11-5-81

11-5-81
11-5-81
11-5-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Louise Frances SUSIE | | | | NOVEMBER 6, 1981 | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| FEMALE | | WHITE | | DEC. 19, 1913 | |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| MARYLAND | | UNITED STATES | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| ESSEX | | FRANKLIN SQUARE HOSPITAL | | HOUSEWIFE | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD | | BALTO | | BALTO | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| JOHN CHARVAT | | KATHERINE DUNN | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | |
| 219-01-2609 | | W. SUSIE 509 PATAPSCO AVE. 21237 | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small cell Carcinoma of the lung with</u> | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>brain metastasis</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 11-2, 1981, to 11-6, 1981, that (we) last saw the deceased alive on 11-6, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | 22b. SIGNATURE A. Vento, M.D. | | 22c. DATE SIGNED 11-6-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. DATE RECD. BY REGISTRAR | |
| A. Vento | | 9000 Franklin Square Drive, 21237 | | NOV 10 1981 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | NOV 10, 1981 | | HOLY REDEEMER | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE RECD. BY REGISTRAR | |
| J.G. CONNELLY, JR. | | 300 MALE AVENUE | | NOV 10 1981 | |

BP

PLANT INDUSTRY

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY, U.S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE REGISTRAR 2039553

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|------------------------------|--|-------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JOSEPH | | TARASEWICZ | | NOVEMBER 17, 1981 | | 1:25 ^A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| MALE | WHITE | SEPTEMBER 15, 1895 | | 86 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| POLAND | U.S.A. | | | BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| FORT HOWARD | | VA MEDICAL CENTER | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| MARYLAND | | | BALTO | | | 622 N. EUTAW STREET | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Tarasewicz | | unk | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| YES | | WWI | | CLINICAL RECORDS, VANC, FORT HOWARD, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). | | LUNG CANCER | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1629 | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 1, 1981, to NOVEMBER 17, 1981, that (I) (we) last saw the deceased alive on NOVEMBER 17, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| SRINIVASAN L. NARASIMHAN, M.D. | | VA MEDICAL CENTER, FORT HOWARD, MD 21052 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 11/19/81 | | Crownsville Vet. | | Crownsville, Md. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR | | | |
| Zannino Funeral Home, 263 S. Conkling St. | | NOV 19 1981 | | Francis J. Nathan | | | |

NOT FOR RELEASE

W. J. R. W. 111

303903

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

NOVEMBER 17, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANK J. TASKA, Sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 18th, 1981 | | | 2b. HOUR M | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 28, 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH Wiltondale, Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Co. 525 Sussex Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Taska | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17 INFORMANT Casimera P. Taska | | ADDRESS Same | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Introschotic Cardiovascular Disease</u> 429.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <u>Peripheral Arterial Disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Charles B. Hatton</i> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 11/18/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles B. Hatton M.D. | | | | | 22e. ADDRESS Osler Med. Center | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Nov. 21, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Co., Md. | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home-6500 York Rd. 21212 | | | | | 25. DATE RECEIVED BY REGISTRAR NOV 23 1981 | | | | |

MEDICAL CERTIFICATION

Investment 1981, 1982

Year 1, 1981, 1982

to

Nov. 1, 1981

1981

1981

Investment 1981, 1982

1981

Investment 1981, 1982

to

Nov. 1, 1981

Investment 1981, 1982

Investment 1981, 1982

to

Nov. 1, 1981

1981

1981

Investment 1981, 1982

to

Nov. 1, 1981

1981

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

Investment 1981, 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 2 8 3 1 1 | |
|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) WALTER J. TELEWICZ | | | | 2a DATE OF DEATH MONTH DAY YEAR 11 19 81 | |
| 3 SEX Male | | 4 RACE White | | 2b HOUR 6:05 M | |
| 5 DATE OF BIRTH MONTH DAY YEAR Jan 27 89 | | 6 AGE (IN YEARS LAST BIRTHDAY) 72 | | IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | |
| 10 CITY OR TOWN OF DEATH Towson Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION St. Agnes Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | |
| 13a STATE Md | | 13b COUNTY Baltimore | | 13c STREET ADDRESS 3129 Clearview Ave 21234 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST EDMUND T. LEWIS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DOUGLAS | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | |
| 16b SOCIAL SECURITY NO. 212-01-8871 | | 17 INFORMANT FAMILY RECORDS | | ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| 5990 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis | | | | day? | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Genito Urinary Tract Infection | | | | day? | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic sclerotic Cardiovascular Disease | | | | | |
| 19a. DATE OF OPERATION X | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 22a. I certify that X (this hospital) attended the deceased from 3-5-83 19 to Nov 19 19 81 , that (1) (see) last saw the deceased alive on Nov 14 19 81 , and that in (X) (my) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John C. Hyle DEGREE MD | | | | 22c. DATE SIGNED 11-19-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. Hyle | | | | 22e. ADDRESS 7527 Belair Rd Balto 21236-4099 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11-23-1981 | | 23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM. | |
| 23d. LOCATION CITY OR TOWN Parkville COUNTY BALTO STATE MARYLAND | | 24 FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPL ADDRESS 8800 HARFORD ROAD | | 25a. DATE REC'D. BY REGISTRAR NOV 21 1981 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

Factor 1. 10.15.1971
Factor 2. 10.15.1971

Factor 3. 10.15.1971
Factor 4. 10.15.1971

Factor 5. 10.15.1971
Factor 6. 10.15.1971

Factor 7. 10.15.1971
Factor 8. 10.15.1971

Factor 9. 10.15.1971
Factor 10. 10.15.1971

Factor 11. 10.15.1971
Factor 12. 10.15.1971

Factor 13. 10.15.1971
Factor 14. 10.15.1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 1 2

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST Jack P. Thacker | | MONTH DAY YEAR Nov 4 1981 | |
| 3. SEX | | 2b. HOUR | |
| MALE | | 11:30 P. | |
| 4. RACE | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| White | | 75 YRS. | |
| 5. DATE OF BIRTH | | 8. BALTIMORE CITY OR COUNTY OF DEATH | |
| MONTH DAY YEAR Sept 17 1906 | | BALTO CO MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| VA | | MECHANIC | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| U.S.A. | | Auto Repair | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | |
| Towson | | 948 FAIRMOUNT AVE | |
| 13a. STATE | | 13b. CITY OR TOWN | |
| MD | | Towson | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST Henry S. Thacker | | FIRST MIDDLE LAST Lottie Hicks | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| NO | | 212-07-8827 | |
| 17. INFORMANT | | ADDRESS | |
| MILRed L. Cortis | | 946 Piney Hill Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of rectum 1541 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from October 1981 to Nov. 1981, that (I) (we) last saw the deceased alive on Oct 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | |
| [Signature] | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED | | 11/6/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| PETER HITZIG | | 300 E. Joppa Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| BURIAL | | 11-8-81 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Bethel Christian Church | | SPOTSylvania | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | |
| EVANS Funeral Chapel | | NOV 12 1981 | |
| 25b. REGISTRAR'S SIGNATURE | | | |
| [Signature] | | | |



10% NOTION %02

WHA 72113

1. The first part of the document is a list of items
 2. The second part is a list of items
 3. The third part is a list of items
 4. The fourth part is a list of items
 5. The fifth part is a list of items
 6. The sixth part is a list of items
 7. The seventh part is a list of items
 8. The eighth part is a list of items
 9. The ninth part is a list of items
 10. The tenth part is a list of items
 11. The eleventh part is a list of items
 12. The twelfth part is a list of items
 13. The thirteenth part is a list of items
 14. The fourteenth part is a list of items
 15. The fifteenth part is a list of items
 16. The sixteenth part is a list of items
 17. The seventeenth part is a list of items
 18. The eighteenth part is a list of items
 19. The nineteenth part is a list of items
 20. The twentieth part is a list of items
 21. The twenty-first part is a list of items
 22. The twenty-second part is a list of items
 23. The twenty-third part is a list of items
 24. The twenty-fourth part is a list of items
 25. The twenty-fifth part is a list of items
 26. The twenty-sixth part is a list of items
 27. The twenty-seventh part is a list of items
 28. The twenty-eighth part is a list of items
 29. The twenty-ninth part is a list of items
 30. The thirtieth part is a list of items
 31. The thirty-first part is a list of items
 32. The thirty-second part is a list of items
 33. The thirty-third part is a list of items
 34. The thirty-fourth part is a list of items
 35. The thirty-fifth part is a list of items
 36. The thirty-sixth part is a list of items
 37. The thirty-seventh part is a list of items
 38. The thirty-eighth part is a list of items
 39. The thirty-ninth part is a list of items
 40. The fortieth part is a list of items
 41. The forty-first part is a list of items
 42. The forty-second part is a list of items
 43. The forty-third part is a list of items
 44. The forty-fourth part is a list of items
 45. The forty-fifth part is a list of items
 46. The forty-sixth part is a list of items
 47. The forty-seventh part is a list of items
 48. The forty-eighth part is a list of items
 49. The forty-ninth part is a list of items
 50. The fiftieth part is a list of items
 51. The fifty-first part is a list of items
 52. The fifty-second part is a list of items
 53. The fifty-third part is a list of items
 54. The fifty-fourth part is a list of items
 55. The fifty-fifth part is a list of items
 56. The fifty-sixth part is a list of items
 57. The fifty-seventh part is a list of items
 58. The fifty-eighth part is a list of items
 59. The fifty-ninth part is a list of items
 60. The sixtieth part is a list of items
 61. The sixty-first part is a list of items
 62. The sixty-second part is a list of items
 63. The sixty-third part is a list of items
 64. The sixty-fourth part is a list of items
 65. The sixty-fifth part is a list of items
 66. The sixty-sixth part is a list of items
 67. The sixty-seventh part is a list of items
 68. The sixty-eighth part is a list of items
 69. The sixty-ninth part is a list of items
 70. The seventieth part is a list of items
 71. The seventy-first part is a list of items
 72. The seventy-second part is a list of items
 73. The seventy-third part is a list of items
 74. The seventy-fourth part is a list of items
 75. The seventy-fifth part is a list of items
 76. The seventy-sixth part is a list of items
 77. The seventy-seventh part is a list of items
 78. The seventy-eighth part is a list of items
 79. The seventy-ninth part is a list of items
 80. The eightieth part is a list of items
 81. The eighty-first part is a list of items
 82. The eighty-second part is a list of items
 83. The eighty-third part is a list of items
 84. The eighty-fourth part is a list of items
 85. The eighty-fifth part is a list of items
 86. The eighty-sixth part is a list of items
 87. The eighty-seventh part is a list of items
 88. The eighty-eighth part is a list of items
 89. The eighty-ninth part is a list of items
 90. The ninetieth part is a list of items
 91. The ninety-first part is a list of items
 92. The ninety-second part is a list of items
 93. The ninety-third part is a list of items
 94. The ninety-fourth part is a list of items
 95. The ninety-fifth part is a list of items
 96. The ninety-sixth part is a list of items
 97. The ninety-seventh part is a list of items
 98. The ninety-eighth part is a list of items
 99. The ninety-ninth part is a list of items
 100. The hundredth part is a list of items

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Genevieve I. Thornberg | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 18, 1981 | | | 2b. HOUR 12 PM | |
| 3. SEX Female | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 22 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holly Hill Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY News Paper | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1H Lakeridge Pl. 21030 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Thornberg | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Curran | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 213-03-2839 | | 17. INFORMANT ADDRESS Mary Ellen Cashmeyer 1H Lakeridge Pl. 21030 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/23/81 19 81 to Nov 18 81 19 81 that (I) we last saw the deceased alive on Nov. 20 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) we did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr. Quinn DEGREE M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 11/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Quinn | | | | | 22e. ADDRESS 1205 York Rd. Balt. Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 21, 81 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell -Wiedefeld 6500 York Rd. | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 25 1981 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 1 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Vincent (NMN) Todaro | | | 2a. DATE OF DEATH MONTH DAY YEAR November 29, 1981 | | | 2b. HOUR 1:15 PM | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5201 Garmouth Road 21229 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber | | 12b. KIND OF BUSINESS OR INDUSTRY Barber Shop | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown to Records | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown to Records | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Mrs. Rose M. Legambi Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Lung with metastasis</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Mediterranean Anemia</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>James E. Rowe</u> M.D. 22c. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Rowe, M.D. | | | | | | 22c. DATE SIGNED 11/30/81 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/1/81 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland | | |
| 24. FUNERAL DIRECTOR NAME MacNabb Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | 25b. REGISTRAR'S SIGNATURE <u>James E. Rowe</u> | | |
| ADDRESS Catonsville, Md. | | | | | | | | |



1-01-11

1-01-11

[Handwritten signature]

1-01-11

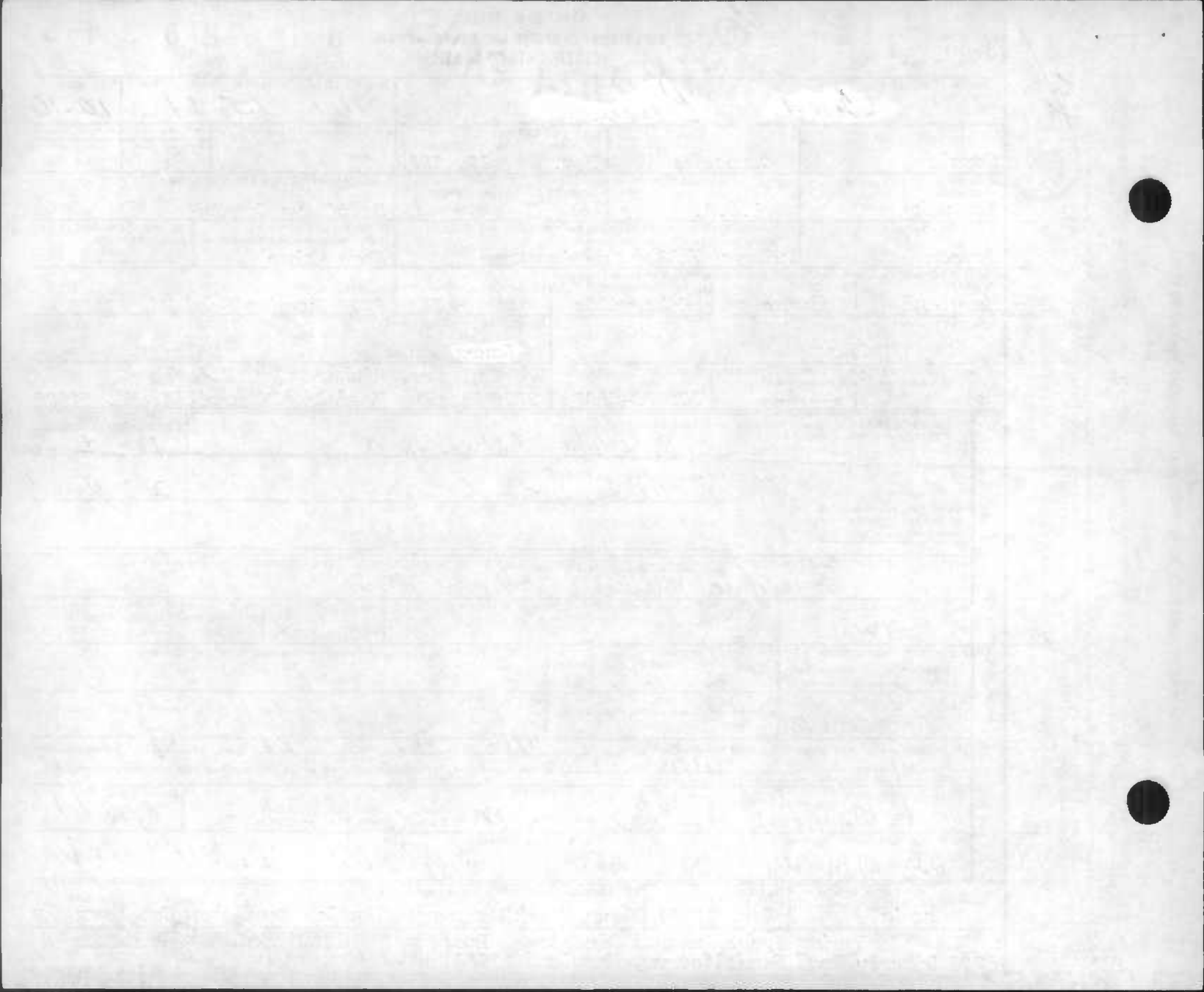
TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 81 28315 | | | |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Genevieve Elizabeth Todd</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>11 15 81</i> | | 2b. HOUR <i>10:10</i> AM | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 17, 1899</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Kentucky</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Towson</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dulaney Valley Nursing Home</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Pikesville</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Loura Holmes</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO <i>302-30-5807</i> | | 17. INFORMANT <i>Mrs. Richard Eliasberg</i> ADDRESS <i>8306 Burning Wood Rd. Pikesville, Md. 21208</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 +</i> | | | |
| 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | (b) <i>carcinoma colon</i> | | | |
| | | | | (c) <i>2 + year?</i> | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes mellitus, impaired vision</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>none</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9/13 19 77</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/15 19 81</i> to <i>10/13 19 81</i> , that (I) (we) last saw the deceased alive on <i>11/15 19 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>R. Maurile Feldman</i> DEGREE | | | | 22c. DATE SIGNED <i>11/15/81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR MAURILE FELDMAN</i> | | | | 22e. ADDRESS <i>6610 CROSS COUNTRY BLVD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Nov. 17, 81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Flour Creek Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Butler Pendleton Co. Kentucky</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, Inc.</i> | | | | 25a. DATE REC'D BY REGISTRAR <i>NOV 17 1981</i> | | | |
| 8728 Liberty Road Randallstown, Maryland 21133 | | | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE L. TORMEY | | | | | | 2a. DATE OF DEATH MONTH 11 DAY 04 YEAR '81 | | 2b. HOUR 2:45A | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 1 DAY 17 YEAR '02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LANDSCAPING | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST F. MIDDLE CARROLL LAST TORMEY | | | | | | 15. MOTHER'S MAIDEN NAME FIRST LILLIAN MIDDLE B. LAST HEVEL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 219-10-1997 | | 17. INFORMANT ADDRESS VIRGINIA C. TORMEY 6132 FALLS RD. 21209 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for each part.) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF STROKE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET 10-17 | | CITY OR TOWN 81 | | COUNTY 11-04 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-17 , 19 81 , to 11-04 , 19 81 that (I) (we) last saw the deceased alive on 11-04 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death. | | | | 22b. SIGNATURE DAVID NEUBAUER, M.D. | | | | DEGREE MD | | 22c. DATE SIGNED 4 Nov. 1981 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS GBMC-6701 N. CHARLES ST. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE NOV. 6, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEM. | | 23d. LOCATION CITY OR TOWN BALTIMORE | | COUNTY MD. | |
| 24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME | | | | ADDRESS 6500 YORK RD. 21212 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 9 1981 | | 25b. REGISTRAR'S SIGNATURE <i>James San Martin</i> | |

BP

APR 2 1961

TORNEY

SECRET

WHITE

MALE

SALT LAKE COUNTY

68MC-2701 W. CHARLES ST.

TO: SOI

STATE OF UTAH

MINISTERS

RECORD

11-11-61 11-11-61 11-11-61

RESPIRATORY ARREST

STOCK

NOTED



22

11-01

81

10-17

81

11-01

68MC-2701 W. CHARLES ST.

DAVID HEBBARD, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE E. TOULAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/24/81 | | 2b. HOUR 7:35 PM |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 7. 22. 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. CO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT NURSING FACILITY, GIVE STREET ADDRESS) ST. JOSEPH'S HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Govt. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. COUNTY BALTO. | 13c. CITY OR TOWN 21204 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael F. Toulan | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann McDonnell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212037921 | | 17. INFORMANT ADDRESS Catherine M. Baxter Balto., MD 21234 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of lung CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from 10/20/81 19 81 to 11/24 19 81 that (b) (we) last saw the deceased alive on 11/24 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Elliott Friedman | | DEGREE MD | | 22c. DATE SIGNED 11/24/81 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Elliott Friedman | | 22e. ADDRESS 25 Penny Ln Balt, Md. 21209 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 28, '81 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 23e. DATE REC'D. BY REGISTRAR NOV 25 1981 | | | |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | ADDRESS 8521 Loch Raven Blvd. | | 25. REGISTRAR'S SIGNATURE Francis J. Nathan | |

BP _____

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1 - STATE REGISTRAR | | 2a DATE OF DEATH MONTH DAY YEAR | | 2b HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| Madeline E. TRAYLOR | | Female | | White | |
| 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | |
| 7 14 1926 | | 55 YRS | | Maryland | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| | | Baltimore County | | Rossville | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Franklin Square Hospital | | Housewife | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Baltimore | | Dundalk | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| Walter D. Rider | | Ethel Marie Reck | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| Not Known | | 525 Nollmeyer Rd. Balto., MD. 21220 | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction with Rupture | |
| | | | | 4100 | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) this hospital attended the deceased from 11/16 19 81, to 11/16 19 81, that (X) (we) last saw the deceased alive on 11/16 19 81, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| Godofredo Stuart, M.D. | | DEGREE | | 11/16/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| | | 9000 Franklin Square Dr., Balto., MD 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 11/20/1981 | | Holly Hill | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| White Marsh Maryland | | NOV 18 1981 | | James J. Nathan | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | | |



~~ABUNDANT~~

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 1 9

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|--|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARMELLO TUMINELLO | | | 2a DATE OF DEATH MONTH DAY YEAR 11-1-81 | | 2b HOUR 1:35 M |
| 3 SEX male | 4 RACE white | 5 DATE OF BIRTH MONTH DAY YEAR 10 20 1917 | | 6 AGE (IN YEARS LAST BIRTHDAY) 64 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10 CITY OR TOWN OF DEATH Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. General Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Western Carloading | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE MD | | 13b COUNTY Balto. | 13c CITY OR TOWN Pikesville | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS 619 Sudbrook Rd. 21208 |
| 14 FATHER'S NAME FIRST MIDDLE LAST Carmello Tuminello | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Imbraguglio | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 218-12-4856 | | 17 INFORMANT ADDRESS Mabel Tuminello 619 Sudbrook Rd. 21208 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PROBABLE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY EDEMA | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ARTERIOSELENERGIC CARDIOVASCULAR DISEASE | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10-21 19 81 P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 10-21 19 81 to 11-1 19 81 , that (I) (we) last saw the deceased alive on 11-1 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Orlando B. Cox | | DEGREE | | 22c DATE SIGNED 11-1-81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. COX, M.D. | | 22e ADDRESS 6064 - RANDALLSTOWN RD. 21133 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 11/4/81 | 23c NAME OF CEMETERY OR CREMATORY Lake View Mem. Park | | 23d LOCATION CITY OR TOWN COUNTY STATE Eldersberg Carroll MD |
| 24 FUNERAL DIRECTOR NAME Loring Byers Funeral Directors ADDRESS 8728 Liberty Rd. Randallstown, Md. 21133 | | | | 25a DATE REC'D. BY REGISTRAR NOV 2 1981 REGISTRAR James J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

7 2 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 3 2 0

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ALBERT FRANKLIN TURNER Jr. | | | 2a. DATE OF DEATH MONTH 11 DAY 7 YEAR 81 | | 2b. HOUR 8:10 AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 1 DAY 30 YEAR 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Randallstown | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 3508 Chapman Road 21133 | |
| 14. FATHER'S NAME FIRST Albert Franklin MIDDLE Turner LAST Sr. | | 15. MOTHER'S MAIDEN NAME FIRST Rosalind MIDDLE Deroyaleux LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-09-4712 | | 17. INFORMANT ADDRESS Mrs. Eleanor Turner 3508 Chapman Road Randallstown, MD. 21133 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100 | | DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) W VENTRICULAR ANEURYSM FROM |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
PREVIOUS MYOCARDIAL INFARCTIONS; DIABETES MELLITUS

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-19-81 to 11-7-81 , that (I) (we) last saw the deceased alive on 11-6-81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | 22c. DATE SIGNED 11-7-81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. COWANAN, MD. | | 22e. ADDRESS BCEH - RANDALLSTOWN, MD 21133 | |

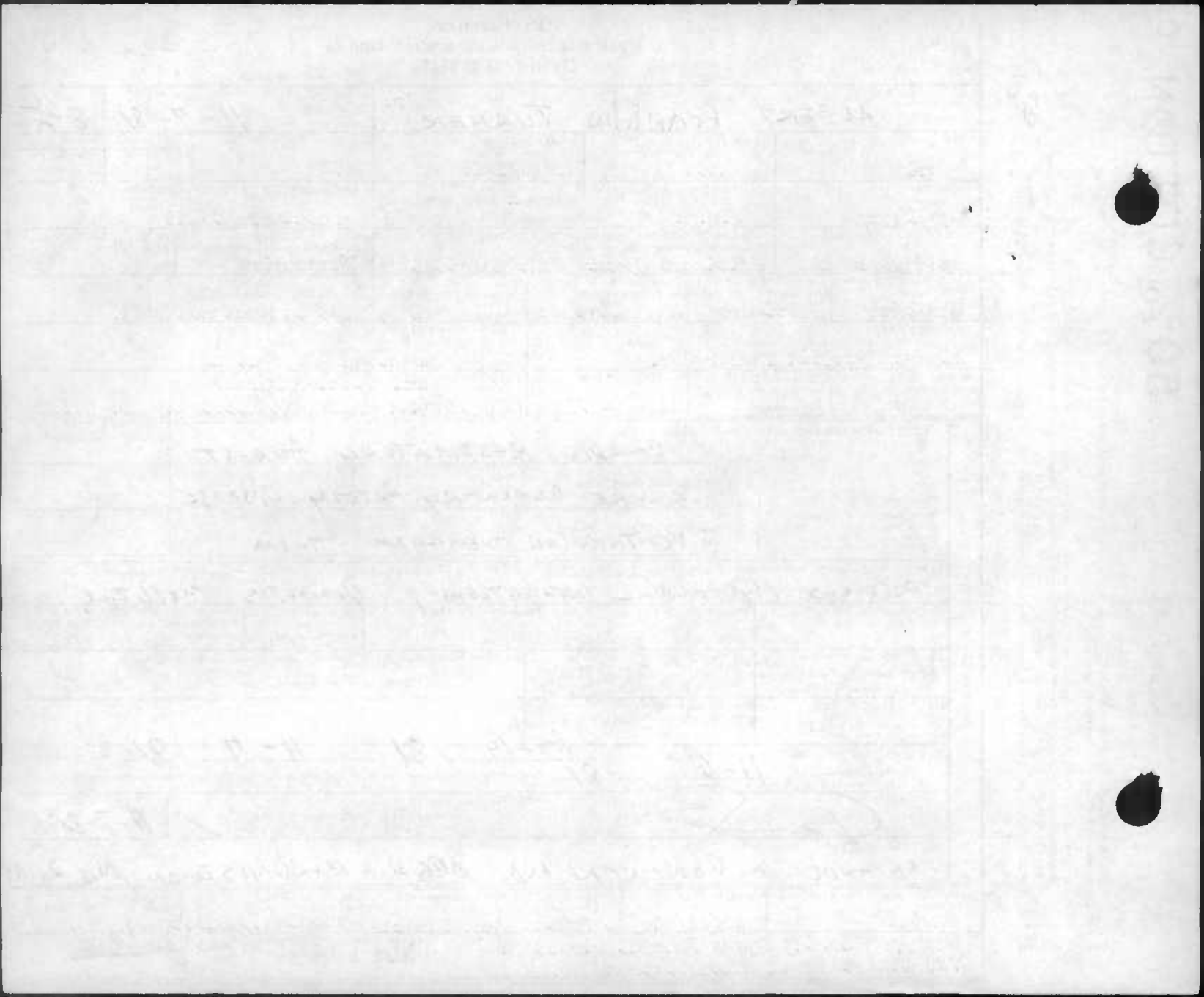
| | | | |
|---|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 11/11/81 | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | 23d. LOCATION CITY OR TOWN Woodlawn COUNTY Baltimore STATE MD. |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors ADDRESS 8728 Liberty Road Randallstown, MD. 21133 | | 25. RECEIVED BY REGISTRAR AND REGISTRAR'S SIGNATURE NOV 10 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 2 1

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) George E. Umphlett | | | 2a. DATE OF DEATH MONTH DAY YEAR November 27, 1981 | | 2b. HOUR 7:30a M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 26 1912 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | 7. IF UNDER 1 YEAR MONTHS DAY HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | |
| 10. CITY OR TOWN OF DEATH Rossville 21237 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Sq. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Government | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Middle River | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 41 Blister St. 21220 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Umphlett | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Benton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (ENTER 9 IF NO WORKING DATES) 1929-49 | 17. INFORMANT ADDRESS Doskie B. Umphlett, Wife Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Carcinoma w/ metastasis to</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>the bone & brain</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 1</u> 19 <u>81</u> , to <u>Nov 11</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Nov 11</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Lucia Zafra Canete M.D.</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED November 27, 1981 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUCIA ZAFRA CANETE M.D. | | 22e. ADDRESS 3100 Wyman Park Drive Balb Md. 21211 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 11/30/81 | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR Name Ruzdzinski Funeral Home PA 1407 Old Eastern Ave. | | 25. DATE REC'D BY REGISTRAR NOV 30 1981 REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

X



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 2 2

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) HERBERT VALENTINE | | | 2a. DATE OF DEATH MONTH DAY YEAR November 3, 1981 | | | 2b. HOUR M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR January 21, 1892 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | |
| 10. CITY OR TOWN OF DEATH Lutherville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) College Manor | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool & Die Maker | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Valentine | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Law | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 565-09-2251 | | | | 17. INFORMANT ADDRESS Mr. Herbert D. Valentine, same as #13e | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from OCT 31st 1981 to NOV 3rd 1981 , that (I) (we) last saw the deceased alive on OCT 31st 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | |
| 22b. SIGNATURE Kevin Quinn M.D. | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/3/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin Quinn, M.D. | | | 22e. ADDRESS 1205 York Road, Timonium, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 11-4-81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Maryland | | | 25a. DATE RECD. BY REGISTRAR NOV 4 1981 | | 25b. SIGNATURE | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11

January 12, 1907

Scotland

Tool & Die Works

Lathe

Lathe

Lathe

Lathe

Lathe

Lathe

Lathe



Lathe

Lathe

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 2 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) GERTRUDE VANCE | | | 2a DATE OF DEATH MONTH DAY YEAR 10-30-81 | | 2b HOUR 4:00am |
| 3 SEX FEMALE | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR AUGUST 5, 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VA. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE MD. | 13b COUNTY BALTO. | 13c CITY OR TOWN BALTO. | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS 36 COLLSTON COURT | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH DAVIS | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSA HARTMAN | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 295 54 038 | | 17. INFORMANT ADDRESS FAMILY RECORDS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) _____ 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) POST COLECTOMY INFECTION | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I (this hospital) attended the deceased from 10-25 , 19 81 , to 10-30 , 19 81 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 10-30 , 19 81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 22b SIGNATURE Pemy Chhim, M.D. | | | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) PEMY CHHIM, M.D. | | | | 22e ADDRESS 7620-YORK ROAD, TOWSON MD 21204 | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 11-2-1981 | | 23c NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK | |
| 23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | 23e NAME OF REGISTRAR NOV 12 1981 | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS EVANS FUNERAL CHAPEL 8800 HARFORD | | 25a DATE REC'D. BY REGISTRAR NOV 12 1981 | | | |
| 25b REGISTRAR'S SIGNATURE Rose J. [Signature] | | | | | |



RECEIVED
MAY 15 1961
LIBRARY

1. The first part of the report is a general
description of the project. It includes a
statement of the purpose of the project, a
brief history of the project, and a
description of the methods used in the
project.

2. The second part of the report is a
detailed description of the project. It
includes a description of the project
area, a description of the project
area, and a description of the project
area.

3. The third part of the report is a
conclusion. It includes a summary of the
project, a summary of the project, and a
summary of the project.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

28324

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hilda E Volkman | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-17-81 | | 2b. HOUR 12:10 AM |
| 3. SEX F | 4. RACE Cau. | 5. DATE OF BIRTH MONTH DAY YEAR 04 09 96 | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Catonsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House In The Pines Catonsville | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Catonsville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 16 Fusting Ave. |
| 14. FATHER'S NAME FIRST MIDDLE LAST late Herman Rottman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Etha | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) A18-32-3641 | | 17. INFORMANT ADDRESS Edna Byron 2020 Edmondson Ave. | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 429.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Chronic - CHF - N/A - (c) DUE TO, OR AS A CONSEQUENCE OF DISEASE - EVD - by 2020 - | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | | | | | |
|---|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-25-75, 19, to 11-17-81, 19, that (I) (we) last saw the deceased alive on 11-5-81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE George H. Witzke | | | | 22c. DATE SIGNED 11-17-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE H WITZKE | | | | 22e. ADDRESS 3350 - Wilkins Dr - Baltimore | |

| | | | |
|--|-------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE Nov 17 '81 | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Pk | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Maryland |
| 24. FUNERAL DIRECTOR NAME Harry H Witzke ADDRESS 4112 Columbia RD Ellicott City | | | 25a. REC'D. BY REGISTRAR NOV 24 1981 |
| | | | 25b. REGISTRAR'S SIGNATURE [Signature] |

12-11-81

- 44 -

5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 2 5

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILMER VOORHEES | | 2a. DATE OF DEATH MONTH DAY YEAR November 6, 1981 | | 2b. HOUR A. M. 10:30 | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1906 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Apt. 309 E Cedar Run Apts. | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Metal | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Ira Wilmer Voorhees | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Hull | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 137-01-3251 | | 17. INFORMANT ADDRESS Douglas Voorhees, 1014 Marksworth Rd. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY 4100 Coronary Thrombosis IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13/77 , 19 77 , to 11/6 , 19 81 , that (I) (we) lost saw the deceased alive on 9/1/77 , 19 77 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Cliff Ratliff, Jr. | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/6/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Cliff Ratliff, Jr. | | 22e. ADDRESS 5772 Westview Mall, Catonsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME 1630 Edmondson Ave., Catonsville, Md Witzke Catonsville Funeral Home, 21228 | | 25a. DATE REC'D. BY REGISTRAR NOV 10 1981 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|---|--|--------------------------|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Leslie E Wade | | | 2a DATE OF DEATH MONTH DAY YEAR 11 3 81 | | 2b HOUR P M 2:00 P | | | | | | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 11 22 18 | | 6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8 IF UNDER 74 HRS HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Villa Nursing Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook | | 12b KIND OF BUSINESS OR INDUSTRY Resteraunt. | | | | | |
| 13a STATE Maryland | | | | | | 13b COUNTY - | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 248 S.Durham St. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George - Wade | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irma - Mullison | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WWII | | 17 INFORMANT ADDRESS Elsie Beaner, 248 S.Durham St. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 1639 DUE TO, OR AS A CONSEQUENCE OF <u>death</u> (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>death</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 11/2/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE <u>Elmo Gayoso</u> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED 11/4/81 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Elmo Gayoso, M. D. | | | | 22e ADDRESS 5411 Old Frederick Rd., Balt., Md. 21229 | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Nov. 9, 1981 | | 23c NAME OF CEMETERY OR CREMATORY Crownsville State V.A. | | 23d LOCATION CITY OR TOWN COUNTY STATE - - Anne Arundel, Md. | | | | | | | |
| 24 FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. | | | | ADDRESS 1901 Eastern Ave. | | | | 25a DATE REC'D. BY REGISTRAR NOV 5 1981 | | 25b REGISTRAR'S SIGNATURE <u>James J. ...</u> | | | |

BP

DHMH-16 25M
(VRA 15, 4) 1/79

| | | | | |
|-------------|--------------------------------|----|------|------|
| George | Wade | 11 | 3 | 2:00 |
| Maryland | Baltimore | 11 | 3 | 2:00 |
| Catonsville | Frederick Villa Nursing Center | 11 | 3 | 2:00 |
| Colorado | U.S.A. | 11 | 3 | 2:00 |
| White | 11 | 3 | 2:00 | |
| Leslie | Wade | 11 | 3 | 2:00 |

Elmo Givens, W. D.
 5411 Old Frederick Rd., Balic, Md. 21229

Elmo Givens, W. D.
 5411 Old Frederick Rd., Balic, Md. 21229

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 3 2 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ESTHER WAINER | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 26, 1981 | | 2b. HOUR 5:40P.M. | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 19, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | |
| 10. CITY OR TOWN OF DEATH PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS APT. 7111 PARK HTS. AVE. 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY GOODELMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF NOT UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-54-0378 | | 17. INFORMANT ADDRESS MRS. EILEEN COHN 6350 RED CEDAR PLA., APT. 309 BALTO., MD 21209 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive HT Failure 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 19 55 to 11/26 19 81 , that (I) (we) last saw the deceased alive above, (I) (we) (did) (did not) view the body (deceased) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE Jerome J. Coller | | 22c. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JEROME J. COLLER | | 22d. ADDRESS 600 REISTERSTOWN RD. | | 22e. DATE SIGNED 11/27/81 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



RECEIVED

[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|---|--|---|--|--|------------------------------------|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 2 8 3 2 8 | | | | | | |
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR HOUR | | | | | | |
| FREDERICK E WALBERT | | | | | NOVEMBER 10, 1981 4:35 PM | | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. IF UNDER 1 YEAR | | | |
| MALE | | WHITE | | MAY 30, 1891 | | 91 YRS | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PENNSYLVANIA | | U.S.A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | BALTIMORE COUNTY | | MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| FORT HOWARD | | V.A. MEDICAL CENTER | | LABORER | | | | | | | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | | | |
| PENNSYLVANIA PIKE | | | | | | | ROUTE 1 | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| YES (YES, NO OR UNKNOWN) WWI | | | | | 204 09 6747 | | CLINICAL RECORDS, VAMC, FORT HOWARD, MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| b) PARKINSONISM | | | | | | | | | | | |
| c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | | | |
| GLAUCOMA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 28, 1981, to NOVEMBER 10, 1981, that (I) (we) last saw the deceased alive on NOVEMBER 10, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | | | | |
| Srinivasan L. Narasimhan | | | | | M.D. | | 11/10/81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | |
| SRINIVASAN L. NARASIMHAN, M.D. | | | | | VAMC, FORT HOWARD, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | | |
| Burial | | | 11/13/81 | | Crownsville Cem. | | Crownsville | | MD | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| ZANNINO Fun. Home - 263 S. CONKLING ST. | | | | | | NOV 20 1981 | | Charles J. Martin | | | |

BP

NOV 1961



THE UNIVERSITY OF CHICAGO
LIBRARY
1001 S. EAST AVE.
CHICAGO, ILL. 60607
U.S.A.

CL. 1001 S. EAST AVE., CHICAGO, ILL. 60607
U.S.A.

NOV 1961

NOV 1961

NOV 1961

MEDICAL CERTIFICATION

DHMH-16 50M 1/81
(VRA 15.4)

Medical Records

REPORT OF PHYSICIAN

DATE OF EXAMINATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 3 0

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHESTER F. WALKER | | | 2a DATE OF DEATH MONTH DAY YEAR Nov. 8 Nov. 8- 1981 | | 2b HOUR 1:30 A M |
| 3 SEX MALE | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR 9 7 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | |
| 10 CITY OR TOWN OF DEATH PIKESVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 25 HOOKS LN. 21208 | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES MAN | | 12b KIND OF BUSINESS OR INDUSTRY RETIRED |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO. 13c. CITY OR TOWN PIKESVILLE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS 25 HOOKS LANE 21208 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM T. WALKER | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES PRICE | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. W.W.I. 215-01-0206 | | 17 INFORMANT ADDRESS CORNELIA A. WALKER (SAME) | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Acute C.V.A. - i cardiac arrest. 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. Cardiac & coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30 AM. Nov. 8 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from May 19 79 to Nov 5 19 81 , that (I) (we) lost saw the deceased alive on Nov 5 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Bernard J. Cohen | | | DEGREE MD | | 22c DATE SIGNED 11/8/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD J. COHEN MD | | | 22e. ADDRESS 76 Maryland ave - 3501 St. Paul St. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11-10-81 | 23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE PIKESVILLE BALTO, MD |
| 24 FUNERAL DIRECTOR NAME NEWELL FUNERAL HOME PIKESVILLE, MD | | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1981 | | |
| | | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 28331 | |
|---|------------------|---|--|---|--------------------------------|---|--|---|--|----------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William E. Walter | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED November 26, 1981 | | 2b. HOUR 12P M | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 10 22 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 58 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD November 26, 1981 | | 2d. HOUR 12P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Rosedale | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1310 Seling Ave 21237 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY Steel | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1310 Seling Ave 21237 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Raymond ----- Walter | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie ----- Schadty | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 215188822 | | 17. INFORMANT ADDRESS Miriam Walter 1310 Seling Ave 21237 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertensive ASCVD</u> } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 yrs</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Charles F. Donnell</u> | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | DATE SIGNED 11/26/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/30/81 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Rosedale Funeral Home Inc. 1211 Chesaco Ave 21237 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 30 1981 | | 25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u> | | | | | |

BP

NOV 20 1954

11/11/54

11/11/54

11/11/54

11/11/54

11/11/54

11/11/54

11/11/54

11/11/54

NOV 20 1954

11/30/54

11/30/54

11/30/54

11/30/54

3

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 3 3 2

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH Raymond WATERS | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 23 81 | | 2b. HOUR 7:05 PM |
| 3. SEX male | 4. RACE Col | 5. DATE OF BIRTH MONTH DAY YEAR 1-17-14 | 6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Ind. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | 13b. COUNTY BALTO. | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WATERS | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura WATERS | | 13e. STREET ADDRESS 1410 Rosedale ST. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-183721 | 17. INFORMANT ADDRESS Mrs. Hattie Waters 1410 Rosedale ST | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe dehydration DUE TO, OR AS A CONSEQUENCE OF (c) Prob. malignancy - | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 3 days 6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/23 19 81, to 11/23 19 81, that (I) (we) last saw the deceased alive on 11/23 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Roberto E. Turnbull | | DEGREE | | 22c. DATE SIGNED 11/23/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roberto E. Turnbull M.D. | | 22e. ADDRESS Balto County Genl Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | 23b. DATE 11-28-81 | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY Balto Ind. | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | ADDRESS 2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | 25b. REGISTRAR'S SIGNATURE Thomas J. Smith |



LIBRARY

1930

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RACHEL WATKINS | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 3 81 | | 2b. HOUR 10:15 AM |
| 3. SEX FEMALE | 4. RACE Col. | 5. DATE OF BIRTH MONTH DAY YEAR 6 18 1914 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HRS MIN. 67 | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (COUNTRY) Howard Co. Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD | | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ross Ford | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA Ford | | 13e. STREET ADDRESS 814 Milford Mill Rd | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. 220-12-7503 | 17. INFORMANT ADDRESS Mrs. Rachel Thuku 814 Milford Mill Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOTENSIVE SHOCK 4148 DUE TO, OR AS A CONSEQUENCE OF (b) ANOXIC ENCEPHALOPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) POST RESPIRATORY ARREST PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) POSSIBLE MYOCARDIAL ISCHEMIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Hafeez A. Syed | | DEGREE | | 22c. DATE SIGNED 11/3/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEEZ A SYED M.D. | | 22e. ADDRESS BALTIMORE COUNTY GEN HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 11-10-81 | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | ADDRESS 22226 North Ave | | 25a. DATE REC'D. BY REGISTRAR NOV 13 1981 | |
| | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a coroner.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|---|---|--|--|---------------------------------------|--|---|---|--|
| REG. NO. 8 1 2 3 3 3 4 | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard Oliver Watts | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 20 1981 | | 2b. HOUR 8 15 A.M. | | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 12 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Camera Man | | 12b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal | | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James G. Watts | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Cownes | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-24-2308 | | 17. INFORMANT F. Marjorie R. Watts | | | ADDRESS 3117 Vulcan Road Balto., MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> <u>4599</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>VASCULAR OCCLUSION, DIABETES MELLITUS, INFECTED SWAMP.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>10/6/81, 10/14/81, 11/7/81, 11/20/81</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>VASCULAR OCCLUSION, INF.</u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10/13</u> , 19 <u>81</u> , to <u>11/20</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11/19</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Kevin P. Keating</u> | | | | | | 22c. DATE SIGNED <u>11/20/81</u> | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN P. KEATING | | |
| 22e. ADDRESS FRANKLIN SQUARE HOSP. | | | | | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN P. KEATING | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 11/23/81 | | | 23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 24 1981 | | | 25b. REGISTRAR'S SIGNATURE <u>James J. Heston</u> | | |

BP _____

100-100000-100000

100-100000-100000

100-100000-100000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

28335

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) IRENE ELIZABETH WATTS. | | | 2a. DATE OF DEATH MONTH 11 DAY 09 YEAR 81 | | 2b. HOUR 10:10 AM |
| 3. SEX F. | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH 1 DAY 5 YEAR 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. James | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unk | | 12b. KIND OF BUSINESS OR INDUSTRY Unk |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MD | 13b. COUNTY Calverton | 13c. CITY OR TOWN Calverton | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 108 Wealey St | |
| 14. FATHER'S NAME FIRST Lawrence E. MIDDLE E. LAST Henderson | | 15. MOTHER'S MAIDEN NAME FIRST Bessie C. MIDDLE Compbell LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-26-6961 | | 17. INFORMANT Alfred WATTS | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE - D.I.C. 5715 DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL VARICES DUE TO, OR AS A CONSEQUENCE OF (c) HEPATIC CIRRHOSIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Bert F. Morton M.D. | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERT F. MORTON | | | | 22e. ADDRESS | |

| | | | |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 11/14/81 | 23c. NAME OF CEMETERY OR CREMATORY Arbutnotown PA | 23d. LOCATION CITY OR TOWN Arbutnotown COUNTY PA STATE |
| 24. FUNERAL DIRECTOR NAME LOCKE FUNERAL HOME ADDRESS 1304 N. Central | | 25a. DATE REC'D BY REGISTRAR NOV 12 1981 | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNIVERSITY OF CHICAGO LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY
1215 EAST 58TH STREET
CHICAGO, ILL. 60637
TEL. 773-936-5000
FAX 773-936-5001
WWW.CHICAGO.EDU



THE UNIVERSITY OF CHICAGO
LIBRARY
1215 EAST 58TH STREET
CHICAGO, ILL. 60637
TEL. 773-936-5000
FAX 773-936-5001
WWW.CHICAGO.EDU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the medical examination must be attached to this certificate.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 3 3 6

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRANK C. WEAVER, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR November 10, 1981 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | |
| 10. CITY OR TOWN OF DEATH Towson | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Penn. R.R.- Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Parkville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 2211 Taylor Ave. |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown Weaver | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | 17. INFORMANT ADDRESS Mrs. Jeanne Weaver 2809 Bauernwood Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia 4920 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) pulmonary emphysema DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/9 19 81 to 11/10 19 81 , that (I) (we) lost saw the deceased alive on 11/9 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Mark S. Kaplan | | DEGREE MD | | 22c. DATE SIGNED 11/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark S. Kaplan, M.D. | | 22e. ADDRESS 16918 York Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 11-12-81 | 23c. NAME OF CEMETERY OR CREMATORY Little Britain Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Nottingham Penn. | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1981 | 25b. REGISTRAR'S SIGNATURE Jeanne Weaver |

BP

Government
Government

100

18

0 3/11/18

AM ~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN Casper WEAVER | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-25-81 | | 2b. HOUR 12:56am |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR February 2, 1898 | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical Helper | 12b. KIND OF BUSINESS OR INDUSTRY Tire | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Sparks | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Washington Weaver | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Fisher | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 212-01-3901 | 17. INFORMANT ADDRESS Cockeysville, Md. 21030 Robert Payne 218 Wickersham Way | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC BRAIN SYNDROME | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18/81, 1981, to 11/25/81, 1981, that (I) (we) last saw the deceased alive on 11/24/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Francis T. Daly | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 11/25/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS T DALY, M.D. | | 22e. ADDRESS 7620-YORK ROAD TOWSON MD 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 11/28/81 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Bikesville, Balto. Co., Md. | | |
| 24. FUNERAL DIRECTOR NAME Martin D. Lawson 10 W. Padonia Road, Timonium | | 25a. DATE REC'D. BY REGISTRAR NOV 27 1981 | | | |
| | | 25b. REGISTRAR'S SIGNATURE Francis T. Daly | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) OTTO E. WEBER | | | 2a DATE OF DEATH MONTH 11 DAY 25 YEAR 81 | | 2b HOUR M |
| 3 SEX MALE | 4 RACE CAUCASIAN | 5 DATE OF BIRTH MONTH Dec. DAY 6 YEAR 1900 | 6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17 WILLOW AVE. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self, employed | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY BALTIMORE 13c CITY OR TOWN BALTIMORE | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS 17 WILLOW AVE. | | |
| 14 FATHER'S NAME FIRST John MIDDLE Weber LAST | | | 15 MOTHER'S MAIDEN NAME FIRST Emma MIDDLE Menard LAST | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 219321185 | 17 INFORMANT ADDRESS DONALD WEBER 17 WILLOW AVE. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic prostate Ca DUE TO, OR AS A CONSEQUENCE OF (c) > 1 yr | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION 5/22/80 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ca prostate | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5/22/80 to 11-25-81 that (I) (we) last saw the deceased on 4/10/81 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b SIGNATURE H. Schonwald | | DEGREE M.D. | | 22c DATE SIGNED 11-25-81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY N. Schonwald, M.D. | | 22e ADDRESS 660 Kenilworth Dr. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 11-30-81 | 23c NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE | |
| 24 FUNERAL DIRECTOR Jeff Cook | | ADDRESS 4210 Belair Rd. | | 25a DATE REC'D. BY REGISTRAR NOV 27 1981 | |
| | | | | 25b REGISTRAR'S SIGNATURE James J. [Signature] | |

BP

7 7 5 7

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Glenell Lashawn WEBSTER | | | 2a DATE OF DEATH MONTH DAY YEAR November 1, 1981 | | 2b HOUR 8:15p M |
| 3 SEX Female | 4 RACE Black | 5 DATE OF BIRTH MONTH DAY YEAR November 1, 1981 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 1 1 9 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10 CITY OR TOWN OF DEATH Baltimore County | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b KIND OF BUSINESS OR INDUSTRY None |
| 13a STATE OF USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 13b CITY OR TOWN Baltimore | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS 6225 Shipview Way |
| 14 FATHER'S NAME FIRST MIDDLE LAST Glenn Webster | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Dunlap | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS Josephine Webster 6225 Shipview Way | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Secondary To Anencephaly 7400 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (1) (this hospital) attended the deceased from November 1, 1981 to November 1, 1981 , that I saw the deceased alive on November 1, 1981 , and that in my opinion death occurred on the date and hour and from the causes stated above. (2) we (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED 11/25/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) D. Durrance Dr. Durrance | | | | 22e ADDRESS 9000 Franklin Square Dr. | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Hosp. Disposed | | 23b DATE 11/19/81 | | 23c NAME OF CEMETERY OR CREMATORY | |
| 24 FUNERAL DIRECTOR NAME None | | ADDRESS | | 25a DATE REC'D. BY REGISTRAR NOV 27 1981 | |
| 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

100% COTTON

WATERPROOF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 4 0

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|---|---|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADOLF WEISGAL | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 15 81 | | 2b. HOUR 6:35 P.M. | |
| 3. SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 13 85 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 74 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY | | 10. CITY OR TOWN OF DEATH Pikesville MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Milford Manor Nursing Home | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CANTOR | | 12b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS MUSIC | | 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 2502 EUTAW PLACE #21217 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SOLOMON WEISGAL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEAH FRIEDMAN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | |
| 16b. SOCIAL SECURITY NO 215-32-1186 | | 17. INFORMANT DR. HUGO WEISGAL 81 MAPLE DR. GREAT NECK, NY 11021 | | 18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease 3 years (c) none PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): none | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 04 23 19 81 to 11 15 19 81, that (I) (we) last saw the deceased alive on 11 15 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Manuel Levin MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 11/15/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D. | | 22e. ADDRESS 6010 PK HTS AVE BALTO MD 21215 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | |
| 23b. DATE NOV. 17, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25. DATE REC'D. BY REGISTRAR NOV 20 1981 | | 25. REGISTRAR'S SIGNATURE [Signature] | | |

BP

DHMH-16 30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 3 4 1

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Sr. Mary Barbara Welsh R.S.M. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 5 81 | | | | 2b. HOUR P M 4:45 P | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 10 4 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH County Balto. MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Villa 6806 Bellona Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeping Sisters of Mercy | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6806 Bellona Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael R. Welsh | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Welsh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-54-1310 | | 17. INFORMANT ADDRESS Sr.M.Elaine Costello 6806 Ballona Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-5-81 to 11-5-81 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11-6-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HIDON E. WALSH | | | | 22e. ADDRESS 333 N. Paul | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/7/81 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell K. Kulep 6500 York Rd | | | | 25a. DATE REC'D. BY REGISTRAR NOV 10 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

20-1-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 1 2 8 3 4 2 | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH M WHITE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 17 81 | | 2b. HOUR 4:13A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 3, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 75 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Baltimore | | | | 13c. CITY OR TOWN Cockeysville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST C. Wilbur Miller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Davison | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 42 9682 | | 17. INFORMANT ADDRESS Davison D. White, Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Bowel infarction DUE TO, OR AS A CONSEQUENCE OF (c) Mesenteric artery occlusion | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART II OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12 , 19 81 , to 11/17 , 19 81 , that (I) (we) lost saw the deceased alive on 11/17 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John E. Adams | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-17-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Adams, M.D. | | | | 22e. ADDRESS 6701 N. Charles St. Towson, MD 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/19/81 | | 23c. NAME OF CEMETERY OR CREMATORY St. John's | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glyndon, Md. | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 19 1981 | | | |

BP

8000 York Road, Baltimore, Md. 21212
Henry W. Jenkins & Sons Co.
Baltimore, Md. 21212

Carlson, Forest, Md.

No. 215 42 8002 Davison D. White, Baltimore, Md.

C. Wilbur Miller Edith Davison

Maryland Baltimore Cockeysville x Falls & Shawan Road

Honorable Mr. Honaker

Maryland USA

White

June 2, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Richard Edgar White | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 11 81 | | | 7b. HOUR 2:40P M | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR October 1, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. Charles St. 21204 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Jockey Agent | | 12b. KIND OF BUSINESS OR INDUSTRY Racing | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Virginia Towers | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lucius E. White | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian S. Harrison | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS Mr. Richard E. White, Jr. 3028 Green Oak Ct. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1439 } DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Cell Cancer of Gingival Sulcus 2 Years Ago (c) Metastatic to Lungs and Mediastinum | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 10/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell cancer of gingival sulcus right radical node dissection | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10, 19 81, to 11/11, 19 81, that (I) (we) last saw the deceased alive on 11/11, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE David Feldman | | | | | | DEGREE 2nd | | 22c. DATE SIGNED 11/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Feldman, M.D. | | | | | | 22e. ADDRESS 6701 N. Charles St. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville V. A. Cem | | 23d. LOCATION CITY OR TOWN COUNTY Crownsville, A. A. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 13 1981 | | 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] | |



NOTICE

WILLIAM

WILLIAM

WILLIAM

WILLIAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Albert Edward Whitestone, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR November 19, 1981 | | | 2b. HOUR M M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | | |
| 10. CITY OR TOWN OF DEATH Owings Mills | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3 Old Coach Lane, Apt. 1D | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad Express Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Owings Mills | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3 Old Coach Lane, Apt. 1D | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Isadore Whitestone | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Legg | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 714-05-6669 | | 17. INFORMANT ADDRESS Mrs. Dollie M. Whitestone, same as #13e | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Obstructive Pulmonary Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/11 19 81 to 11/19 19 81 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert B. Kroopnick | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert B. Kroopnick, M.D. | | | | 22e. ADDRESS 8726 Liberty Plaza Mall | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-23-81 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) Cockeysville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 23 1981 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | | | |

BP

November 19, 1901

Howard, Wisconsin, U.S.A.

Dear Sir,

I have

been

very

much

x

U.S.A.

Very

Yours

Very

Very

Very

x

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

2 8 3 4 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sophia Beckmann Wilhelm | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 1 81 | | 2b. HOUR 12:00 P ^M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 13 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Lochearn | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Augsburg Lutheran Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY -- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. COUNTY XXXXXXX | | 13c. CITY OR TOWN Baltimore |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herman C Beckmann | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosina M. Bachmann | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 579-10-5033 | | 17. INFORMANT ADDRESS Augsburg Lutheran Home 6811 Campfield Rd., Baltimore, MD 21207 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio pulmonary arrest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C. VD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-30 , 19 81 , to 11-1 , 19 81 , that (I) (we) lost saw the deceased alive on 11-1 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not give the body over for death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-2-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. NAIR | | 22e. ADDRESS 5010 York Road, BALT MD 21226 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/4/81 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Raysville Baltimore MD | | 24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors 8728 Liberty Rd., Randallstown, MD 21133 | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE James San Martin | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

11 1 51 12:00

Beckmann, William

Female White B 12 1968

USA X

Housewife Husband's Name

No. 66666 City X 615 Washington Ave

Herman Beckmann Rosina

270-10-5000

Office for Research

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

100-10-1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | 2a DATE OF DEATH MONTH DAY YEAR | | 2b HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 3 SEX | | 4 RACE | |
| FIRST MIDDLE LAST | | Female | | Caucasian | |
| Rebecca Wise | | | | | |
| 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | |
| 12 10 07 | | 73 YRS | | Maryland | |
| 8 MARried <input type="checkbox"/> NEVER MARried <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 IF UNDER 1 YEAR MONTHS DAYS | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| | | | | Baltimore County MD | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Catonsville | | House in the Pines-Catonsville | | Unemployed | |
| 12b KIND OF BUSINESS OR INDUSTRY | | 13a STATE | | 13b COUNTY | |
| Never Worked | | Maryland | | Baltimore | |
| 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 326 Woodlawn Road | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| George Stewart Wise | | Rebecca Skinner | | No | |
| 16b SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | |
| 213-10-8528 | | Cornelia S. Wise, Rt. 1 Box 109 | | Baltimore, Md. 22660 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4292 Cardiac arrest | | | | | |
| Atherosclerotic CVD | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 11/8 to 11/8, 1970, that (I) (we) last saw the deceased alive on 11/8, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | |
| Herbert L. Levickas MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 11/9/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | |
| Dr. Herbert Levickas | | 5404 East Drive, Baltimore, MD 21227 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | |
| Burial | | 11/11/81 | | Greenmount Cemetery | |
| 23d LOCATION CITY OR TOWN | | 23e DATE REC'D. BY REGISTRAR | | 23f REGISTRAR'S SIGNATURE | |
| Baltimore | | NOV 13 1981 | | Thomas Jan. North | |
| 24 FUNERAL DIRECTOR NAME | | 24b ADDRESS | | 25a DATE REC'D. BY REGISTRAR | |
| Witzke P.A. | | 1630 Edmondson Avenue, Catonsville, Maryland 21228 | | NOV 13 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10-10
10-10-10
10-10-10

10-10-10

10-10-10
10-10-10

10-10-10
10-10-10
10-10-10

10-10-10

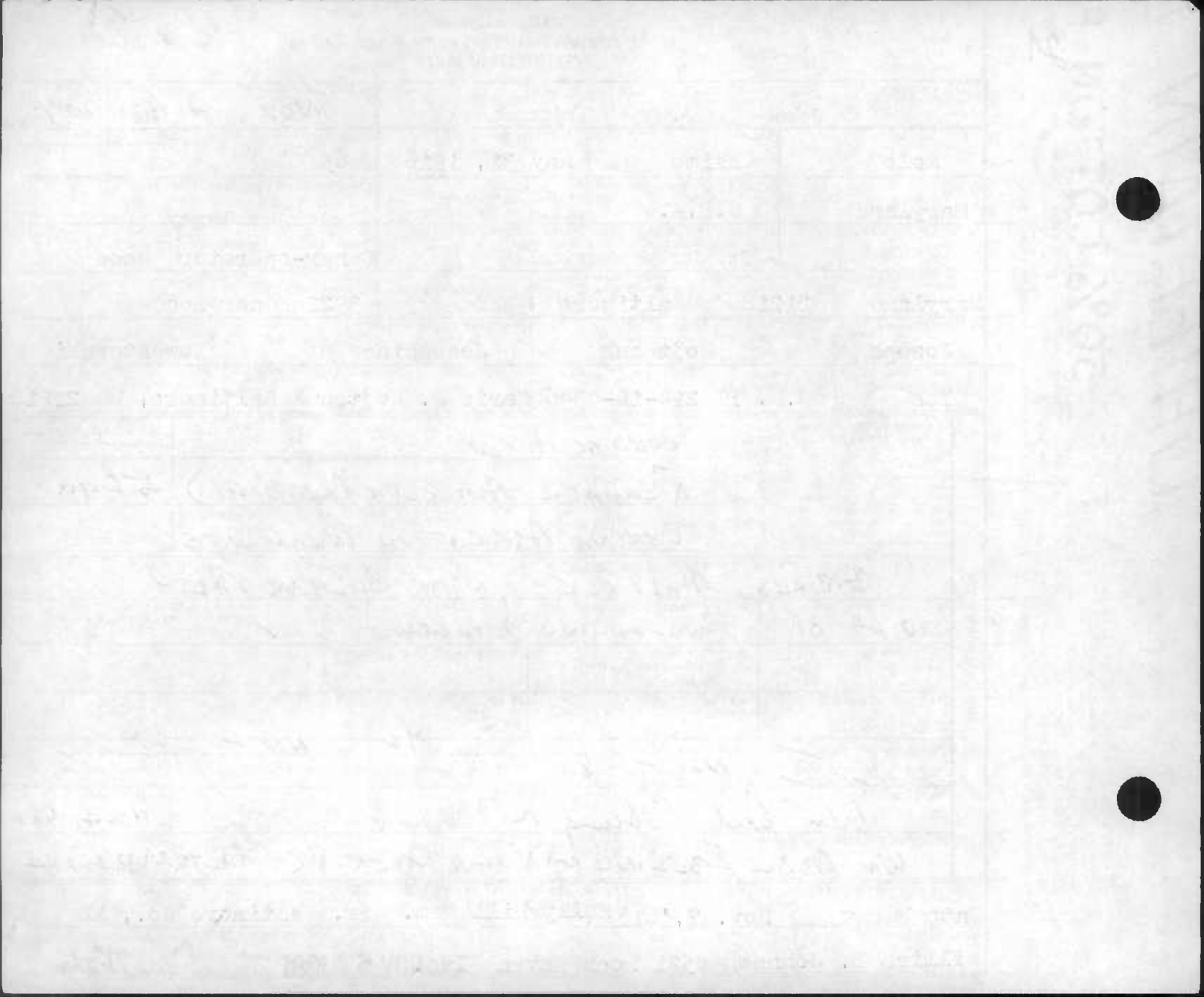
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 8 3 4 7

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John A. Wojtczuk | | | 2a. DATE OF DEATH MONTH DAY YEAR NOV 4 1981 | | | 2b. HOUR MIN. 10:00 P | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 31, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-operator | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY 21218 | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Wojtczuk | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Zowostowski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 214-10-0346 | | 17. INFORMANT ADDRESS Maria D. Wojtczuk Baltimore, MD 21218 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 3989 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) RHEUMATIC-ARTICULAR CARDIOMYCLD. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ASPIRATION PNEUMONITIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 ± yrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (d) S-ROKES, MULTIPLE, WITH BULBAR PARLY | | | | | | | | | |
| 19a. DATE OF OPERATION 10-29-81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SWALLOWING DISTURBANCE | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 72 to NOV 4 19 81 , that (I) (we) lost the deceased alive on NOV 4 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Wm Carl Ebeling MD | | DEGREE | | 22c. DATE SIGNED NOV 4, 1981 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm CARL EBELING MD | | 22e. ADDRESS 7401 OSLER DR. BALTIMORE 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE Nov. 7, '81 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gar. Baltimore Co., MD | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | ADDRESS 8521 Loch Raven Blvd | | 25a. DATE REC'D. BY REGISTRAR NOV 6 1981 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TILLY WOLF | | | 2a. DATE OF DEATH MONTH DAY YEAR NOV. 25, 1981 | | 2b. HOUR 4:33 PM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 1989 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL MARMORSTEIN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | |
| 16b. SOCIAL SECURITY NO. 213-74-1920 | | 17. INFORMANT ADDRESS MRS. ELAINE SULS 2807 MARNAT RD. APT. F (21209) | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) AS LVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROPRIATE INTERVAL BETWEEN PART I AND PART II 8 AM 15+yr | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0 M | | | | | | |
| 19a. DATE OF OPERATION M | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5/6 19 81 to 11/25 19 81 | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/25 19 81 to 11/25 19 81 , that (I) (we) last saw the deceased alive on 11/25 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Maurice Feldman MD | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/25/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURICE FELDMAN | | 22e. ADDRESS 6610 CROSS COUNTRY BLVD. (21215) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11-27-81 | | 23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN, MD. |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1981 | | |
| 25b. REGISTRAR'S SIGNATURE Thomas J. Nathan | | | | | | |



NOTION 2002

11/11/02

11/11/02

11/11/02

11/11/02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Emilie Phelps Wolfe</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>11-18-81</i> | | 2b. HOUR <i>7:45 P</i> |
| 3 SEX <i>F</i> | 4 RACE <i>W</i> | 5 DATE OF BIRTH MONTH DAY YEAR <i>2 21 96</i> | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>85</i> | | IF UNDER 1 YEAR IF UNDER 24 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD | | |
| 10 CITY OR TOWN OF DEATH <i>Catoonsville</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Neck Nursing Home</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> |
| 13a. STATE <i>MD</i> | | 13b. COUNTY <i>Howard</i> | 13c. CITY OR TOWN <i>Ellicott City</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>John Henry Phelps</i> | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Dora Hartley</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>315 22 9830</i> | | 17 INFORMANT ADDRESS <i>Elaine I. Jones Ellicott City Md.</i> | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sepsis</i> 4380 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decubitus ulcers</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ECVA</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>5 months</i> <i>13 months</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION <i>—</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from <i>Jan. 10</i> , 19 <i>81</i> , to <i>Nov. 18</i> , 19 <i>81</i> , that (I) was lost saw the deceased alive on <i>Nov. 18</i> , 19 <i>81</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) do (did) not view the body after death. | | | | | |
| 22b. SIGNATURE <i>David R. Moser</i> | | DEGREE <i>M.D.</i> | | 22c. DATE SIGNED <i>11-18-81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David R. Moser, M.D.</i> | | 22e. ADDRESS <i>4713 Leeds Ave Arbutus, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>11-21-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ellicott City Howard Md.</i> | | | | | |
| 24 FUNERAL DIRECTOR NAME <i>Maught Funeral Home Sykesville, Md.</i> | | ADDRESS <i>—</i> | | 25a. DATE REC'D. BY REGISTRAR <i>NOV 23 1981</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Jean Nathan</i> | |

BP

THE UNIVERSITY OF CHICAGO
LIBRARY
520 EAST 58TH STREET
CHICAGO, ILL. 60637

DATE

CALL

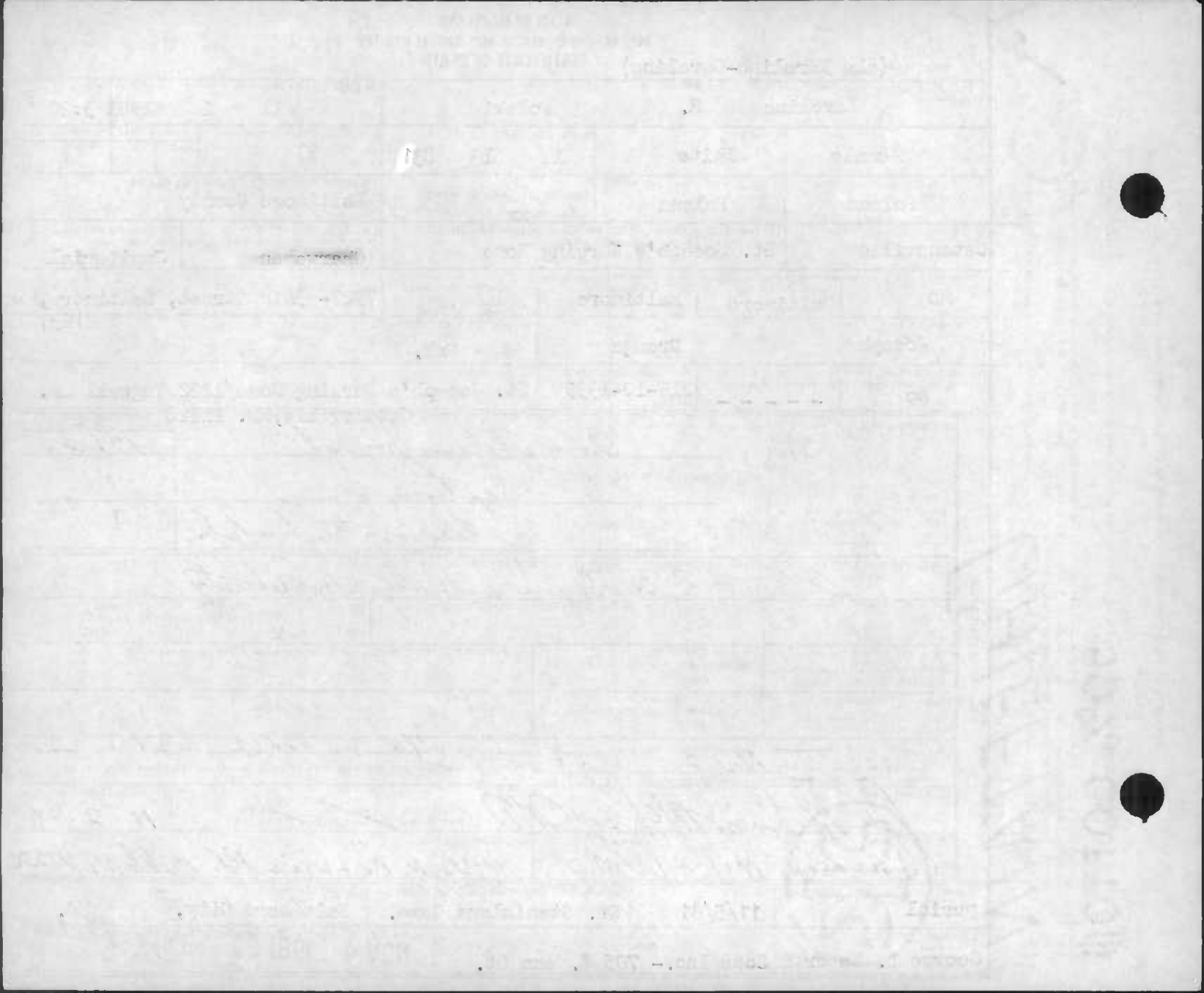


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

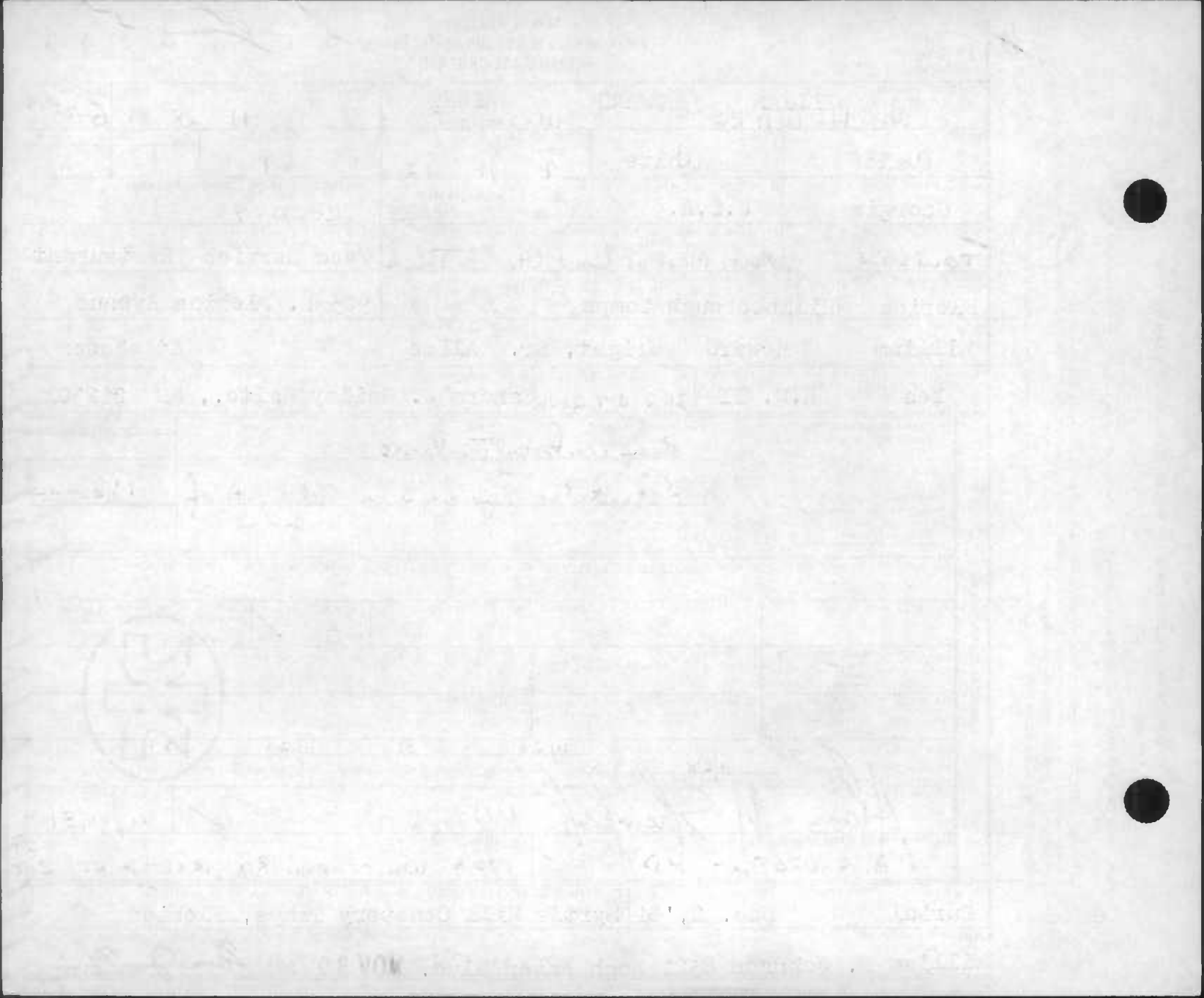
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|--|--|
| 1 - FOR STATE REGISTRAR (aka Karoline-Caroline) CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Karolina R. Wolski | | | | | 2a DATE OF DEATH MONTH DAY YEAR 11 2 1981 | | | 2b HOUR 3:20 P M | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 11 13 83 | | 6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | 7b CITIZEN OF WHAT COUNTRY? Poland | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | |
| 10 CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Nursing Home | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Charwoman | | 12b KIND OF BUSINESS OR INDUSTRY Janitorial | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD | | | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Joseph Drenga | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk. 21237 | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b SOCIAL SECURITY NO. 215-10-1339 | | 17. INFORMANT ADDRESS St. Joseph's Nursing Home/1222 Tugwell Dr. Catonsville, MD. 21228 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ornithelasma Infection</u> 5990 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Plmonary tract infarct</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 1 7 | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Alcohol - acute decompensation with severely disability</u> | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Nov 2</u> 19 <u>81</u> to <u>Nov 2</u> 19 <u>81</u> that (I) <u>was</u> lost saw the deceased alive on <u>Nov 2</u> 19 <u>81</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE <u>D. Nelson McKay MD</u> DEGREE MD | | | | | 22c DATE SIGNED 11-2-81 | | | 22d MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT) D. NELSON MCKAY, M.D. | | | | | 22f ADDRESS 1132 N. RELLING RD. BALLO MD 21228 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 11/5/81 | | 23c NAME OF CEMETERY OR CREMATORY St. Stanislaus Ceme. | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md. | | | |
| 24 FUNERAL DIRECTOR NAME George A. Weber & Sons Inc. - 705 S. Ann St. | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 4 1981 | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u> | | | | | | | | | | |



IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | 8128351 | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 3. SEX | | | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| 13a. STATE | | | | | | 13b. INSIDE CITY LIMITS? | | | | 13c. STREET ADDRESS | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED | | | |
| 21d. INJURY OCCURRED | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body immediately. | | | | | | 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| W. HOWARD WRIGHT | | | | | | 11 28 81 | | | | 6:10 PM | | | |
| Male | | | | | | White | | | | 7 11 12 | | | |
| Georgia | | | | | | U.S.A. | | | | 69 YRS. | | | |
| TOWSON | | | | | | MULTI-MEDICAL CTR. of Towson | | | | Food Service | | | |
| Florida | | | | | | Hillsborough Tampa | | | | 905 N. Florida Avenue | | | |
| William Howard Wright, Sr. | | | | | | Alice Stepheson | | | | | | | |
| Yes | | | | | | W.W. II | | | | 262-09-2606 | | | |
| Sandra W. Bailey | | | | | | Balto., MD | | | | 21230 | | | |
| 1659 | | | | | | Respiratory Failure | | | | 1 1/2 mos | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED | | | |
| 21d. INJURY OCCURRED | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/23, 1981, to 11/28, 1981, that (I) (we) lost saw the deceased alive on 11/28, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body immediately. | | | | | | 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| Burial | | | | | | Dec. 2, '81 | | | | Myrtle Hill Cemetery Tampa, Florida | | | |
| William E. Johnson | | | | | | 8521 Loch Raven Blvd. | | | | NOV 30 1981 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 8 1 2 8 3 5 2 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES S. YAKER | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-30-81 | |
| 3. SEX MALE | | | | | | | | | | 2b. HOUR 5-10 A.M. | |
| 4. RACE WHITE | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | |
| 5. DATE OF BIRTH MONTH DAY YEAR APR. 1, 1895 | | | | | | | | | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA | | | | | | | | | | 7b. IF UNDER 24 HRS. HOURS MIN. | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MASTER PLUMBER | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY PLUMBER | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP. | | | | | | | | | | | |
| 13a. STATE MARYLAND | | | | | | | | | | 13b. CITY OR TOWN BALTIMORE | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13d. STREET ADDRESS 3221 SHELBURNE RD. #21208 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL YAKER | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRIAM GOLDENBERG | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | | | | | | 16b. SOCIAL SECURITY NO. 218-14-8559 | |
| 17. INFORMANT MISS BEATRICE YAKER | | | | | | | | | | 17. ADDRESS 3221 SHELBURNE RD. BALTO., MD 21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest 20 to 4100 DUE TO, OR AS A CONSEQUENCE OF (b) acute inf-wale ME, Cardio gene DUE TO, OR AS A CONSEQUENCE OF (c) Shock and CHB & CHF. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-23-1981 to 11-30-1981 , that (I) (we) last saw the deceased alive on 11-23-1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE R.M. Shah | | | | | | | | | | DEGREE | |
| 22c. DATE SIGNED 11-30-81 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH | | | | | | | | | | 22e. ADDRESS 600 B.C.H. OLD COURT S. LIBERTY RD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | | | | 23b. DATE DEC. 1, 1981 | |
| 23c. NAME OF CEMETERY OR CREMATORY BETH JACOB | | | | | | | | | | 23d. LOCATION FINKSBURG CARROLL MD | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR DEC 4 1981 | |
| 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | | | | | | | | | |

BP



WEST-MOTOR CO.

DAVID M. F. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 4).

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert L. Yarrington SR. | | 2a. DATE OF DEATH MONTH DAY YEAR NOV. 11, 1981 | | 2b. HOUR M 11 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 06 01 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 79 | | IF UNDER 24 HRS. HOURS MIN. 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY | | 10. CITY OR TOWN OF DEATH ESSEX | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 925 PUNJAB CIRCLE | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY BETH ST. | | 13a. STREET ADDRESS 925 PUNJAB CIRCLE | |
| 13b. CITY OR TOWN ESSEX | | 13c. CITY OR TOWN ESSEX | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK | | 16. SOCIAL SECURITY NO. 213-07-8349 | |
| 17. INFORMANT LENNY YARRINGTON | | 18. ADDRESS RUN RD. 30 STEMMERS RD. JEN | | 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 80 , to October 27, 19 81 , that (I) (we) last saw the deceased alive on October 27, 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dean R. Taylor MD | | DEGREE MD | | 22c. DATE SIGNED 11/13/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Dean R. Taylor | | 22e. ADDRESS 9101 Franklin Square Drive Suite 214 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE NOV. 13, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill M.C. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. 21237 | | 23e. DATE REC'D. BY REGISTRAR NOV 17 1981 | | 23f. REGISTRAR'S SIGNATURE James S. [Signature] | |
| 24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME | | ADDRESS 300 MALE AVE | | | |

BP

